Name:_____ **SS#:**_____

FORM F
AFFIDAVIT OF APPLICANT

CURRENT PASSPORT PHOTO

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards or other governmental or law enforcement agencies.

I acknowledge and state that I have read and am familiar with the Respiratory Care Practice Act and rules pertaining thereto. I further state that by filing this application for certification as a Respiratory Care Professional in the State of Georgia, I authorize and consent to have an investigation made as to my moral character, profession reputation and fitness to practice as a Respiratory Care Professional. I agree to give any further information that may be required in reference to my past record. I understand that I will not receive a copy of the report or know its contents and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, Federal or foreign) court, association, institution, or any other organization having control of any documents, records or other such information pertaining to me, to furnish to the Georgia Composite Medical Board any such documents, records regarding charges or complaints filed against me formal or informal, pending or closed, or any other pertinent data and permit the Georgia Composite Medical Board or any of its agents or representatives to inspect and make copies of such documents, records or other information, in connection with this application, subsequent to practice thereunder.

I authorize and request the Georgia Composite Medical Board to obtain any criminal history information concerning me from any authorized law enforcement agency including but not limited to the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC).

I hereby release, discharge and exonerate the Georgia Composite Medical Board for any and all liability of every nature and kind arising out of the furnishing or inspections of such documents, records or other information or any investigation made by the Georgia Composite Medical Board to release information, material, documents, orders or the like relating to me or to this application to any other agency or any other agency of the State of Georgia, the medical licensing agency of any other state or territory of the United States, or Province of Canada, the Federation of State Medical Boards, or the US Inc., law enforcement agency, hospital or other appropriate agencies as determined by the Board.

I hereby swear or affirm under penalties of perjury that all statements made by me in this application and any attachments hereto and made a part hereof are true and correct. I understand that pursuant to the Official Code of Georgia Annotated. Section 43-43-46, any person who shall give false or forged evidence of any kind to the Board in connection with an application, shall be guilty of a felony and upon conviction thereof, shall be punished by paying a fine of not less than $500 nor more than $1000 or by imprisonment from two to five years or both.

SIGNATURE OF APPLICANT	DATE	CITY	COUNTY	STATE

PRINTED NAME OF APPLICANT	Being duly sworn, says that he/she is the person who executed the above application and that all the statements herein contained are true and that the attached photo is a true photo of the applicant.	NOTARY SEAL MUST BE IMPRINTED HERE

Sworn and subscribed before me this _____day of _____20_____, _

_____(Notary Public)

My Commission Expires

_____