FORM B
REFERENCE FORM – INITIAL PHYSICIAN LICENSURE

To Applicant: The GEORGIA COMPOSITE MEDICAL BOARD requires completion of **three (3)** reference forms, **one** each from licensed physicians who have known you and have been familiar with your practice for more than six months. Formal letters of reference are not accepted in lieu of the Reference Form since questions on the form are required by the Georgia Composite Medical Board. The Program Director or Physician will complete the form and send it directly to **you. Do not open the envelope**; send it with your application packet. **Altered envelopes which contain official, original, certified official documents will not be accepted.**

Please mail your form with your application packet to:

GEORGIA COMPOSITE MEDICAL BOARD
ATTENTION: PHYSICIAN LICENSURE
2 Peachtree Street, NW 6th Floor
Atlanta, GA 30303

In addition, the forms must meet the following criteria:

a. Sent by a licensed physician familiar with your practice and who have known you **more than six months**.
b. **Original signature** and date of signature of reference source.
c. The date of the reference source's signature is **invalid** six months of the date it was signed.
d. It is preferable that one be sent by the Program Director or Chief of Service for those who have recently completed residency training, or the last hospital where staff privileges were held.
e. The Board **does not accept faxed copies of the forms**.

Applicant, be sure to indicate your name and address below for identification purposes.

NAME OF APPLICANT: _____

ADDRESS: _____

CITY, STATE AND ZIP CODE: _____

To Reference Source: Please complete this form, sign, date, and return to the **applicant** in a **sealed envelope** at the above stated address. Your response is confidential, pursuant to Georgia law. All applicants are required to sign a general release, which relieves anyone of any liability for information furnished in good faith. Please print or type all information. Please make sure the applicant's name is indicated on the form. The Physician should complete the reference form and return it to the **applicant.** The processing time for licensure directly depends on timely receipt of critical forms such as this.

ATTENTION: *The person who signs this form **MAY NOT** be related to the applicant by blood, marriage, or adoption.*

THIS POINT FORWARD IS TO BE COMPLETED BY THE REFERENCE SOURCE:

From:

First | Middle Initial | Last | Degree (MD/DO/MBBS)

Address | City | State | Zip

Area code | Phone Number

Area code | FAX Number

1. How long have you known this physician?

[years] [months]

2. In what capacity are you acquainted with this physician?

FORM B - CONTINUED
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PLEASE CONFIRM THAT THE FOLLOWING RESPONSES ARE CORRECT BEFORE SUBMITTING THIS FORM. INAPPROPRIATE ANSWERS WILL RESULT IN A DELAY IN PROCESSING YOUR APPLICATION.

If you answer "YES" to questions 1-7, please provide an explanation.

	Yes	No
1. Have you ever received reports of poor medical practice by this physician, or have you discussed concerns you had about this physician's practice with medical staff officers at a hospital?	❑	❑
2. Have you ever received reports of poor relationships between this physician and other members of hospital staff?	❑	❑
3. Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	❑	❑
4. Does this physician have, or has this physician had in the past, any mental or physical illnesses or personal problems that interfere with his/her medical practice?	❑	❑
5. Has this physician ever abused alcohol or drugs or shown signs of chemical dependency?	❑	❑
6. Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	❑	❑
7. Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	❑	❑

If you answer "NO" to questions 8-11, please provide an explanation.

	Yes	No
8. Does this physician accept medical staff and hospital policies and function willingly according to these policies?	❑	❑
9. Does this physician enjoy professional respect among his/her colleagues and in the community where applicant practices?	❑	❑
10. Are you sorry to see this physician leave your community?	❑	❑
11. Do you recommend this physician for unrestricted medical licensure in Georgia?	❑	❑

If you have any comments regarding this applicant, please put your response in writing and attach it to this form. Please sign, provide your title, name of hospital if applicable and the date.

SIGNATURE **TITLE**

HOSPITAL (IF APPLICABLE) **DATE**