FORM E
INSTITUTIONAL PHYSICIAN
TERMINATION NOTIFICATION FORM

Should any institutionally licensed physician wish to terminate licensure, he/she shall notify the Georgia Composite Medical Board of this intention in writing by certified mail or by hand delivery and shall immediately return his/her license to the Board. Should a disciplinary proceeding by the Board be pending at the time of such surrender, such surrender shall have the same effect as a revocation of a license and be reportable as a disciplinary action.

Do NOT complete this form if you are not TERMINATING from your current supervising OVERSIGHT physician at this time.

PLEASE PRINT LEGIBLY:

INSTITUTIONAL PHYSICIAN STATEMENT:

I hereby serve notice to the Georgia Composite Medical Board that

_____ **is no longer an INSTITUTIONAL physician**
(Institutional Physician Name)

EMPLOYED AT:

_____
NAME OF INSTITUTION

_____**effective:**_____/_____/_____.
(license number) (Month) (Day) (Year)

_____ _____
Institutional Physician Signature **Date Signed**

SUPERVISORY OVERSIGHT PHYSICIAN STATEMENT:

I hereby serve notice to the Georgia Composite Medical Board, that I am no longer serving as a supervisory oversight physician for:

_____
(Institutional Physician Name)

effective:_____/_____/_____
(Month) (Day) (Year)

_____ _____ _____
Supervisory Oversight Physician Signature **Date Signed** **License Number**

Also complete this section if applicable:

I am unable to contact Dr._____to obtain his/her signature to be released from supervisory oversight. I have attempted to contact her/him through:

( ) email

( ) telephone

( ) US Postal Service or other similar means

( ) personal visit to the office

_____ _____

Institutional Physician Signature **Date Signed**