BOARD USE ONLY – DO NOT WRITE IN THIS SECTION	
DATE STAMP	**Receipt Number:**
	Amount:
	License Number:
	Initials/Date:

PAIN CLINIC APPLICATION
REQUEST TO CHANGE OWNERSHIP OF PAIN CLINIC

PAIN MANAGEMENT CLINIC - OFFICE INFORMATION

CURRENT REGISTERED NAME OF PAIN CLINIC:

_____

Federal Tax Identification Number (FEI#) OR Employer Identification Number:

_____

Pain-Management Clinic Physical Address: ***(P.O. Boxes are not acceptable)***

_____
(Street) (Suite #)

_____
(City) State (Zip Code) (County)

Mailing Address:

_____
(Street) (Suite #)

_____
(City) State (Zip Code) (County)

Pain Management Clinic Telephone Number: _____

Pain Management Clinic Fax Number: _____

Pain Management Clinic Email Address: _____

EFFECTIVE DATE OF CHANGE IN OWNERSHIP:

_____

Will the name of the clinic change? _____YES _____NO

If yes, new name of the clinic:

_____

FEI #:_____

PAIN MANAGEMENT CLINIC - OFFICE INFORMATION (con't)

1. List the business operating hours.

Business Operating Hours:

Monday	___: ___am/pm **to** _: ___am/pm
Tuesday	___: ___am/pm **to** _: ___am/pm
Wednesday	___: ___am/pm **to** _: ___am/pm
Thursday	___: ___am/pm **to** _: ___am/pm
Friday	___: ___am/pm **to** _: ___am/pm
Saturday	___: ___am/pm **to** _: ___am/pm
Sunday	___: ___am/pm **to** _: ___am/pm

1a. Clinic accepts the following form(s) of payment for services rendered: **(CHECK ALL THAT APPLY)**

Cash	_____YES	_____NO
Cash Only	_____YES	_____NO
Medicaid	_____YES	_____NO
Medicare	_____YES	_____NO
Credit Card	_____YES	_____NO
Private Insurance:	_____YES	_____NO

Other:_____

2. Person to be contacted for communication, or notice and citation matters:

Name: _____Title: _____

Address: _____

Phone #: (____) _____-_____

EMAIL ADDRESS: _____

3. Type of drugs you wish to dispense:
   ( ) Prescription Drugs (Other than controlled substances)
   ( ) Controlled Substances

CURRENT OWNERSHIP INFORMATION

Provide the current ownership information on this page.

1. Type of Ownership: ( ) Individual ( ) Partnership ( ) Corporation

2. Percentage of Ownership by Georgia physician: _____

   If you are **NOT** 100% physician owned, circle below to indicate which exemption you fall under.

   A. Pain management clinic **jointly owned** by one or more physician assistants or advanced practice registered nurses and one or more physicians?

   B. Pain management clinic **NOT majority owned** by physicians licensed in this state?

3. State of Incorporation: _____
   (If Applicable)

4. List the names and addresses of any and all pain-management clinic owner(s), principal(s), officer(s), agent(s), and managing employee(s). **NOTE:** IF YOU HAVE MORE THAN ONE OWNER, PRINCIPAL, OFFICER, AGENT AND/OR MANAGING EMPLOYEE, **use additional sheets to list the information.**

Owner Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

Principal Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

Officer Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

Agent Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

Managing Employee Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

NEW OWNERSHIP INFORMATION

Provide the new ownership information on this page.

1. Type of Ownership: ( ) Individual ( ) Partnership ( ) Corporation

2. List the names and addresses of any and all pain-management clinic owner(s), principal(s), officer(s), agent(s), and managing employee(s). **NOTE:** IF YOU HAVE MORE THAN ONE OWNER, PRINCIPAL, OFFICER, AGENT AND/OR MANAGING EMPLOYEE, **use additional sheets to list the information.**

Owner Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

Principal Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

Officer Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

Agent Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

Managing Employee Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

NEW OWNER QUESTIONNAIRE

	EVERY OWNER, PRINCIPAL, OFFICER AND AGENT MUST COMPLETE THE OWNER QUESTIONNAIRE. ALL YES ANSWERS MUST BE SUPPORTED WITH DOCUMENTATION AND EXPLANATION.	**YES**	**NO**
1.	Are you a US Citizen?		
2.	Do you own more than one pain management clinic? (If yes, submit a copy of your current license at pain management clinic).		
2a.	Do you have, or ever had, another pain management clinic in another state? If yes, list the state(s). _____		
3.	Has the clinic ever had the license revoked or otherwise disciplined by a state or federal agency?		
4.	Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? **NOTE: If you are currently enrolled in GAPHP, you may check NO.**		
5.	Have you ever been convicted of a felony, entered a plea bargain, been arrested, indicted or convicted for violating any state or federal law including DUI (excluding minor traffic violations)? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding, or the affording of Frist Offender Treatment, regardless of whether the adjudication of guilt or sentence is withheld or not entered. If yes, provide a personal narrative of the circumstances surrounding the incident and include a copy of the charges, plea or jury verdict, and final disposition, sentence, probation, and payment of fines		
6.	Has any licensing Board or other state or federal agency ever taken a **public or private** disciplinary action against you?		
7.	Have you ever been refused renewal of a certificate or a license by any licensing Board or other state or federal agency?		
8.	Are you currently registered with the DEA?		
9.	Have you ever been denied a DEA registration number?		
10.	Have you ever been issued a restricted DEA registration?		
		YES	**NO**

	NEW OWNER QUESTIONNAIRE - (con't)		
11.	Have you ever surrendered a DEA registration or controlled substance registration?		
12.	Have you ever had your federal registration to prescribe, distribute, or dispense controlled substances suspended or revoked?		
13.	Have you ever been convicted of a crime under any state or federal law relating to any controlled substance? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding or the affording of First Offender Treatment, regardless of whether the adjudication of guilt or sentence is withheld or not entered.		
14.	Have you ever surrendered a medical license?		
15.	Have you ever been, or currently the subject of an investigation by any licensing Board or other state or federal agency?		
16.	Do you currently have any applications for a pain management clinic license pending before any other licensing Board or agency? If yes, list licensing Board or agency:_____		
17.	Have you ever had any restrictions or been terminated as a Medicaid or Medicare provider in any state? If yes, provide documentation to indicate that you were reinstated and in good standing with the Medicaid Program.		
18.	Are you currently in default on child support payments?		

I acknowledge and state that I have read the instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Medical Practice Act and the Board Rules. This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that pursuant to the Official Code of Georgia Annotated, Section 43-34-46, 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 a fine of not less than $500.00 nor more than $1,000.00, or by imprisonment from two to five years, or both.

_____

Printed Name of Applicant:

_____

Signature of Applicant

_____

Date

AFFILIATED PERSONNEL INFORMATION: Complete the section below for each practicing physician who will be employed at the clinic. If you have <u>more than one practicing physician working in your clinic,</u> copy this sheet and list the information.

Practicing Physician Name:	
License Number/Profession:	
Address:	
Telephone Number:	
DEA Number:	Email Address:

Hours Designated Physician Present in Clinic:

Monday	___: ___am/pm **to** _____: _am/pm
Tuesday	___: ___am/pm **to** _____: _am/pm
Wednesday	___: ___am/pm **to** _____: _am/pm
Thursday	___: ___am/pm **to** _____: _am/pm
Friday	___: ___am/pm **to** _____: _am/pm
Saturday	___: ___am/pm **to** _____: _am/pm
Sunday	___: ___am/pm **to** _____: _am/pm

Does the practicing physician listed above currently work at any other pain clinic? ____YES___NO
(This includes any pain clinic location, **other than the one identified on page 1**, even if it is one of your other locations)

1. If Yes, list pain clinic name: _____

Pain Clinic Location: _____

List hours present in clinic: _____

2. If Yes, list pain clinic name: _____

Pain Clinic Location: _____

List hours present in clinic: _____

AFFILIATED PERSONNEL INFORMATION: Complete the section below for the physician assistant who will be employed at the clinic. If you have <u>more than one physician assistant working in your clinic,</u> copy this sheet and list the information.

Physician Assistant Name:	
License Number/Profession:	
Address:	
Telephone Number:	
DEA Number:	Email Address:
Supervising Physician Name:	
Supervising Physician License Number:	

Hours Designated Physician Assistant Present in Clinic:

Monday	___: ___am/pm **to** _____: _am/pm
Tuesday	___: ___am/pm **to** _____: _am/pm
Wednesday	___: ___am/pm **to** _____: _am/pm
Thursday	___: ___am/pm **to** _____: _am/pm
Friday	___: ___am/pm **to** _____: _am/pm
Saturday	___: ___am/pm **to** _____: _am/pm
Sunday	___: ___am/pm **to** _____: _am/pm

Does the physician assisted listed above currently work at any other pain clinic? ____YES___NO
(This includes any pain clinic location, **other than the one identified on page 1**, even if it is one of your other locations)

If Yes, list pain clinic name: _____

Pain Clinic Location: _____

List hours present in clinic: _____

A. Will the physician assistant be prescribing controlled substances at this location? ___YES __NO

B. If yes, does the physician assistant have an approved job description at this location? ___YES __NO

Complete the section below for the APRN who will be employed at the clinic. If you have <u>more than one APRN working in your clinic,</u> copy this sheet and list the information.

APRN Name:	
License Number/Profession:	
Address:	
Telephone Number:	
DEA Number:	Email Address:
Delegating Physician Name:	
Delegating Physician License Number:	

Hours Designated APRN Present in Clinic:

Monday	___: ___am/pm **to** _____: _am/pm
Tuesday	___: ___am/pm **to** _____: _am/pm
Wednesday	___: ___am/pm **to** _____: _am/pm
Thursday	___: ___am/pm **to** _____: _am/pm
Friday	___: ___am/pm **to** _____: _am/pm
Saturday	___: ___am/pm **to** _____: _am/pm
Sunday	___: ___am/pm **to** _____: _am/pm

Does the APRN listed above currently work at any other pain clinic? ____YES___NO
(This includes any pain clinic location, **other than the one identified on page 1**, even if it is one of your other locations)

If Yes, list pain clinic name: _____

Pain Clinic Location: _____

List hours present in clinic: _____

A. Will the APRN be prescribing controlled substances at this location? ___YES __NO

B. If yes, does the APRN have an approved physician protocol agreement at this location? __YES__NO

SECTION IV: PERSONNEL CERTIFICATION FORM

INSTRUCTIONS:

This form should be completed by each **OWNER, PRINCIPAL, OFFICER, AGENT, MANAGING EMPLOYEE AND LICENSED HEALTH CARE PRACTITIONERS** named in the application.

All information requested on this form is mandatory. Failure to provide any and all of the requested information will result in an incomplete background investigation and rejection of the application. This information will be used to determine your qualifications to work in a pain clinic. This information may be shared with other government agencies upon receipt of an official request.

NAME: _____

SEX: ____**MALE** _____**FEMALE**

STREET ADDRESS: _____

_____

City **State** **Zip Code**

Date of Birth: _____

Social Security Number: _____

Telephone: _____

Fax: _____

Pain Clinic Name: _____

Position with the Pain Clinic: (check below all those that apply)

____Owner	____Principal	____Officer	____Agent
____Managing Employee	____Practicing Physician	____Physician Assistant	____APRN

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed.

Print Name: _____

Applicant Signature: _____

Date: _____