ATTACH CHECK HERE

GEORGIA COMPOSITE MEDICAL BOARD
EFFECTIVE
JULY 1, 2001
ALL FEES ARE NONREFUNDABLE

Initial Physician Assistant Application

Be sure to review the application checklist before submitting your application.

Name and Personal Detail

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. §651 and 20 U.S.C.A. § 1001. This information may also be disclosed to the National Practitioner Data Bank or other state medical boards or regulatory agencies for license tracking purposes.

☐ **Check here if you would like to request a temporary license upon completion of your application**

Social Security Number _____

Last Name (Surname) _____

First _____

Middle _____

Other Surnames _____

Gender ☐ Male ☐ Female

Birth Date (mm/dd/yy) ____/____/____

Contact Detail Summary

General Addresses

Mailing Address: Correspondence from the Board is sent to this address. Email address is utilized by the Board to contact you in case of an emergency situation. This address will not appear on the Internet *unless you **fail** to provide a practice location address*.

_____
Street Number Street Name City State Zip Apt

_____ Email: _____@_____
Area Code Phone Number

Practice Location: Posted on the Internet when the license number is issued.
!!Your mailing address will appear on the Internet if you do not provide a practice location!!

_____
Street Number Street Name City State Zip Suite/Bldg

_____
Area Code Phone Number Email: _____@_____

PHYSICIAN ASSISTANT
APPLICANT QUESTIONNAIRE

	IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO ATTACH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON, AND DISPOSITON OF THE MATTER (INCLUDE COPIES OF COURT ORDERS OR MALPRACTICE SUITS IF APPLICABLE) AND MAIL THIS FORM WITH APPROPRIATE DOCUMENTS DIRECTLY TO THE GEORGIA MEDICAL BOARD.	**YES**	**NO**
1.	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 answer NO.	___	___
2.	Have you 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, regardless of whether the adjudication of guilt or sentence is withheld or not entered.	___	___
3.	Have you ever been denied the privilege of taking an examination by any State licensing board or been denied a certificate/licensure, or refused renewal of a certificate or license by any licensing board or agency?	___	___
4.	Has any licensing Board or agency ever taken a **public or private** disciplinary action against you?	___	___
5.	Are you currently registered with the DEA? If yes, provide the number and state of issue below: DEA Number _____ State of issue_____	___	___
6.	Have you ever been named as a party in a malpractice suit, arbitration hearing, military review, State Review panel proceeding, or VA/federal agency review?	___	___
7.	Have you ever had your hospital privileges limited, denied or revoked?	___	___
8.	Have you ever relinquished your hospital privileges?	___	___
9.	Have you ever voluntarily surrendered a DEA registration?	___	___
10.	Have you ever voluntarily surrendered your PA certificate/license?	___	___
11.	Do you have any applications for licensure pending before any other licensing Board or agency?	___	___
12.	Have you ever had any restrictions as a Medicaid or Medicare provider?	___	___

	PHYSICIAN ASSISTANT APPLICANT QUESTIONNAIRE (con't)	**YES**	**NO**
13.	Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	___	___
14.	Have you ever defaulted on child support payments?	___	___
15.	Have you served in the armed forces? If yes, please provide copy of DD214.	___	___
16.	Are you a Georgia state employee? If yes, enter the Facility Name:_____	___	___
17.	Are you a Georgia county employee? If yes, enter the Facility Name:_____	___	___
18.	Have you ever taken the NCCPA Exam? If yes, enter date of Last Exam: _____ (MM/DD/YYYY)	___	___
19.	Are you currently certified by the NCCPA? If yes, enter Certificate #:_____	___	___
20.	Have you ever taken the NCCAA exam? If yes, enter date of Last Exam: _____ (MM/DD/YYYY)	___	___
21.	Are you currently certified by the NCCAA? If yes, enter Certificate #::_____	___	___
22.	Are you a U.S. Citizen? (If no, please refer to the applicant checklist listed on our website for acceptable documentation)	___	___

If you are not a U.S. citizen, you must submit documentation that will determine if you have a qualified alien status. **Only those applicants who can provide proof will be granted a license.** The Board participates in the **DHS-USCIS SAVE** (Systematic Alien Verification for Entitlements or "SAVE") program for the purpose of verifying citizenship and immigration status information of non-citizens. In order to confirm your status with the SAVE program, you need to provide the board with **legible** copies of **one** of the documents listed on our website.

License History

List all states in reverse chronological order that you are/have been licensed to practice as a PA by virtue of a certification issued by another duly constituted licensing Board in the United States as follows:

State	Date Licensed From (mm/dd/yyyy)	Date Licensed To (mm/dd/yyyy)	License Number	Licensure Status Active/Inactive)

College Education Information

List name and location of college attended and date of attendance/graduation date.

School Name	From (mm/dd/yyyy)	To (mm/dd/yyyy)	City, State	Graduation Date (mm/dd/yyyy)

Utilization of Physician Assistant or Anesthesiologist Assistant

Provide information for the Physician(MD/DO) requesting utilization of PA/AA.

PA/AA Name: _____

Physician GA License Number: _____

Physician First Name: _____

Physician Middle Name: _____

Physician Last Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Business Phone: _____

Specialty: _____

***If specialty is Pain Management, please refer to pain management rules and regulations for additional requirements REQUIRED to practice.

Type of Primary Practice Setting (clinic, hospital, ER/Urgent care, Telemedicine, etc):

_____

Telemedicine Practice: Yes_____ No_____ If you checked "yes":

Please provide the physical address in which the PA will be using to provide Telemedicine services.

_____

_____