GCMB Use Only

File Number: _____

Date Issued: _____

License Number: _____

Institutional Physician License Application

All fees are nonrefundable and subject to change.

This license is jointly awarded to the applicant and the institution.

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.

Social Security Number _____

Last Name (Surname) _____

First _____

Middle _____

Other Surnames _____

Degree ☐ MD ☐ DO ☐ MBBS Specialty: _____

Gender ☐ Male ☐ Female

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

Contact Detail Summary

Institutional Address: This address will appear on the Board Website

Street Number Street Name City State Zip Suite/Bldg

Area Code Phone Number Email

Applicant Questionnaire:

YES responses require a personal explanation and supporting documentation. Submit your documentation directly to the Board.	**YES**	**NO**
1. During the last seven years, were you treated for alcohol, mental or physical disorder, chemical drug dependency, neurologic, or psychiatric illness that required outpatient evaluation or inpatient hospitalization? (If yes, provide treatment history documentation to include diagnosis, treatment regimen, hospitalization, and ongoing treatment/medication to the Board.	❑	❑
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 given by any licensing Board or Agency?	❑	❑
4. Has any licensing Board or agency ever denied you a certificate or a license?	❑	❑
5. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	❑	❑
6. Have you ever been named as a party in a malpractice suit, arbitration hearing, review panel proceeding or any other legal proceedings regarding the practice of medicine?	❑	❑
7. Have you ever resigned from a hospital staff position or training program after a complaint or peer review action has been initiated against you?	❑	❑
8. Have you ever been denied membership in, or in any way sanctioned, by any medical or osteopathic association, society, or specialty society?	❑	❑
9. Have you ever surrendered a medical license?	❑	❑
10. Have you ever surrendered a controlled substance registration, if applicable?	❑	❑
11. To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?	❑	❑
12. Do you have any applications for licensure pending before any other licensing Board or agency? If yes, provide a list.	❑	❑
13. Are you in default on child support payments?	❑	❑
14. Have you ever defaulted on a state or federally funded and/or guaranteed school loan?	❑	❑

15. Please provide your practice plans in Georgia below:

_____

Program Questions

1. What examinations have you taken?			
2. How long have you lived in the US?	_____years _____months		
3. Have you served in the U.S. Armed Forces? Dates of service: From:_____ To:_____ (mm/dd/yy) (mm/dd/yy) If yes, provide a copy of Military Discharge Paperwork		☐ Yes	☐ No
4. Are you Board certified in your specialty? If yes, provide specialty and name of certifying board. _____ Specialty _____ Certifying Board		☐ Yes	☐ No
5. Are you a U.S. Citizen?		☐ Yes	☐ No

If you are not a U.S. citizen, but a qualified alien under the Federal Immigration and Naturalization Act 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 the Boards checklist requirement.

License History

Original verifications of license history certification are required for each permanent, temporary, training, institutional, provisional, or limited licensed obtained in any Province. The issuing authority should mail the verification directly to the Georgia Composite Medical Board. If licensed by examination, give the country. Provide the current status of the license: active, inactive, revoked, suspended, probation, limited.

__________ **Country** ______________________ **Status** ____________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

__________ **Country** ______________________ **Status** ____________________

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__________ **Country** ______________________ **Status** ____________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

Print this page if you have more state history to list.

PRE-MEDICAL/MEDICAL EDUCATION

Beginning month and ending year for each year of attendance is required.

College _____

1st.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
2nd.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
3rd.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
4th.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
5th.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
6th.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)

Medical Education

Beginning month and ending year for each year of attendance is required.

Medical School _____

1st.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
2nd.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
3rd.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
4th.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
5th.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
6th.	**Year**	From:	_____	(mm/yy)	TO:	_____	(mm/yy)

Post Graduate Training

Provide listing of hospitals where postgraduate training has been completed or ongoing and specialty.

Specialty _____

Hospital _____

Address _____

City/State/Zip _____

Specialty _____

Hospital _____

Address _____

City/State/Zip _____

Hospital Privileges

Have you ever held any hospital privileges? ☐ Yes ☐ No

Hospital _____

Address _____

City/State/Zip _____

Print this page if you have more information to list.

AFFIDAVIT OF APPLICANT

TOP OF PHOTO (HEAD)

Paste or Staple a 2 ¼ x 3 inch photo here.

Photo must be of your Head and Shoulder Area only.

BOTTOM OF PHOTO (SHOULDERS)

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 the Application for Institutional Licensure Information and Applicant 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, copies of which are sent to applicants.

I further state that by filing this application for license to practice medicine in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I request and authorize any treatment program to release alcohol and drug abuse patient records to the Georgia Composite Medical Board for the purpose of evaluating my fitness to practice. The consent of this paragraph is subject to revocation pursuant to federal regulations and terminates upon the date of termination of medical licensure in Georgia.

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

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, its agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Composite Medical Board.

I hereby swear or affirm under penalties or 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 43-34-46, any person who shall give false or forged evidence of any kind to the Board in connection with an application for a license to practice medicine 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: _____ Date: _____

Signature of Applicant: _____

Being duly sworn, says that he/she is the person who executed the application for an institutional license in the State of Georgia; that all the statements herein contained are true in every respect; and that the attached photo is a true photo of the applicant.

Affix the Notary Seal/Stamp In this space.

Sworn and subscribed to me this ____ day of _____ in the year _____.

Signature of Public Notary: _____

My Commission Expires: _____

Exceptional Circumstances Consideration Form
Physician

To qualify for Exceptional Circumstances consideration, the physician applicant must be a graduate of an international medical school and cannot qualify for licensure under other provisions of Chapter 43-34-26 and must submit evidence acceptable to the Board to demonstrate exceptional circumstances.

Please print legibly:

Institutional Physician Name _____
Last Name **First Name** **Middle**

Institutional Physician Specialty:_____

Institution Name: _____

Institution Address:_____

_____
City **State** **Zip Code** **Phone Number**

DO YOU MEET THE FOLLOWING REQUIREMENTS

1. Are you from a war torn country? If yes, provide documentation from State Department.
   _____YES _____NO

2. Have you applied for political asylum in the United States? If yes, provide proof.
   _____YES _____NO

3. Are you a graduate of an international medical school and do not qualify for licensure under other provisions of Chapter 43-34-26?
   _____YES _____NO

NOTE: The Board may require the physician applicant and a representative of the institution to appear for a personal interview before the Board or the committee.

_____ _____
Applicant Physician Signature **Date Signed**

Return the completed form to:
Georgia Composite Medical Board
Attention: Institutional Physician Licensure
2 Peachtree Street, N.W., - 36th Floor
Atlanta, GA 30301