



GEORGIA COMPOSITE MEDICAL BOARD

ATTACH CHECK HERE

EFFECTIVE
JULY 1, 2001
ALL FEES ARE NONREFUNDABLE

NOTE: IF YOU ARE APPLYING FOR AN ADMINISTRATIVE OR TELEHEALTH LICENSE YOU CANNOT APPLY FOR A DEA)

Check this box if you are applying for an Administrative License (non-clinical practice)

Check this box if you are applying for a Telehealth license (NOTE: YOU CANNOT

Initial Physician 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.

Social Security Number _____

Last Name (Surname) _____

First Middle _____

Other Surnames _____

Degree MD DO Specialty _____

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

Area Code Phone Number Email @

Practice Location/Administrative Office 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/office location!!**

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.

- | | 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 check NO. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been denied the privilege of taking an examination given by any licensing Board or Agency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has any licensing Board or agency ever taken a public or private disciplinary action against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has any licensing Board or agency ever refused you renewal of a certificate or a license? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been denied a DEA registration number? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been issued a restricted DEA registration? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you currently registered with the DEA?
If yes, provide DEA number _____ and State of Issue _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been named as a party in a malpractice suit, arbitration hearing, State Review panel proceeding, or a VA/Federal agency review? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever resigned from a hospital staff position or training program after a complaint or peer review action has been initiated against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever been denied membership in, or in any way sanctioned, by any medical or osteopathic association, society, or specialty society? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever surrendered a medical license? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever surrendered a controlled substance registration? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever surrendered a DEA registration? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have any applications for licensure pending before any other licensing Board or agency? If yes, provide a list. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had any restrictions as a Medicaid or Medicare provider? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are you in default on child support payments? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you intend to practice medicine in Georgia? Please provide your plans below: | <input type="checkbox"/> | <input type="checkbox"/> |
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Program Questions

1. What examinations have you taken? USMLE NBME COMLEX _____ State Board
 LMCC FLEX NBOME Structured Examination
2. How long have you lived in the US? _____ years _____ months
3. Have you served in the U.S. Armed Forces? If yes provide a copy of Military Discharge Paperwork Yes No
4. Are you Board certified in your specialty? Yes No
 If yes, provide specialty _____
5. Will you be using FCVS? Yes No
6. Are you a US Citizen? Yes No

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 on the enclosed list.

License History

Provide history for each permanent, temporary, training, provisional, or limited licensed obtained in any state in the US, Canadian Territory or Province, or US Federal Jurisdiction.

State _____	Country _____	Status _____
Issued From: _____	(mm/dd/yy)	To: _____ (mm/dd/yy)
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State _____	Country _____	Status _____
Issued From: _____	(mm/dd/yy)	To: _____ (mm/dd/yy)
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State _____	Country _____	Status _____
Issued From: _____	(mm/dd/yy)	To: _____ (mm/dd/yy)
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State _____	Country _____	Status _____
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State _____	Country _____	Status _____
Issued From: _____	(mm/dd/yy)	To: _____ (mm/dd/yy)
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License History (continued)

State	_____	Country	_____	Status	_____
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State	_____	Country	_____	Status	_____
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Medical/Osteopathic Education

Pre-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)
7th. Year	From: _____	(mm/yy)	TO: _____	(mm/yy)
8th. Year	From: _____	(mm/yy)	TO: _____	(mm/yy)
9th. 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)
7th. Year	From: _	(mm/yy)	TO: _____	(mm/yy)
8th. Year	From: _	(mm/yy)	TO: _____	(mm/yy)
9th. Year	From: _____	(mm/yy)	TO: _____	(mm/yy)

Post Graduate Training

Specialty _____

Hospital _____

Address _____

City/State/Zip _____

Specialty _____

Hospital _____

Address _____

City/State/Zip _____

Print page if you have more to list.



Hospital Privileges

Have you ever held any hospital privileges? Yes No

Hospital

Address

City/State/Zip

Hospital

Address

City/State/Zip

Hospital

Address

City/State/Zip

Hospital

Address

City/State/Zip

Hospital

Address

City/State/Zip

Hospital

Address

City/State/Zip

Print page if you have more hospitals to list