FORM B

REFERENCE FOR REINSTATEMENT ORTHOTIST AND PROSTHETIST LICENSURE

To Applicant: The GEORGIA COMPOSITE MEDICAL BOARD requires completion of TWO **(2)** references. Formal letters of reference are not accepted in lieu of the Reference Form since questions on the form are required by the Board. Have the reference sources complete the form and send it directly to **you. Do not open the envelope**; send it with your application packet. **Altered envelopes which contain official, original, certified official documents will not be accepted.**

Please mail your form with to:

Georgia Composite Medical Board
ATTENTION: ORTHOTIST AND PROSTHETIST LICENSURE
2 Peachtree Street, NW - 6th Floor
Atlanta, GA 30303

In addition, the reference forms must come from the following individuals:

a. **1 reference from current or former patients FROM EACH RESPECTED DISCIPLINE**. **Custom shoes, foot orthotics, and/or knee braces are not accepted.**
b. **1 reference from referral sources FROM EACH RESPECTED DISCIPINE (i.e., physicians, physical therapists, case managers, etc.)**
c. The Board **does not accept faxed copies of the reference form**.
d. Please be specific of the types of orthoses or prothosis provided or referred.

Applicant, be sure to indicate your name and address below for identification purposes.

NAME OF APPLICANT: _____

ADDRESS: _____

CITY, STATE AND ZIP CODE: _____

To Reference Source: Please complete this form, sign, and return to the **applicant** in a **sealed envelope** at the above stated address. Your response is confidential, pursuant to Georgia law. All applicants are required to sign a general release, which relieves anyone of any liability for information furnished in good faith. Please print or type all information.
Please make sure the applicant's name is indicated on the form. **Sign your name across the back of the envelope.** The processing time for licensure directly depends on timely receipt of critical forms such as this.

ATTENTION: The person who signs this form MAY NOT be related to the applicant by blood, marriage, or adoption, unless the person is your current employer.

THIS POINT FORWARD IS TO BE COMPLETED BY THE REFERENCE SOURCE:

Please **print legibly:**

From: _____
First Middle Initial Last Degree

_____
Address City State Zip

_____
Area code Phone Number

_____
Area code FAX Number

FORM B - CONTINUED

REFERENCE FOR REINSTATEMENT ORTHOTIST AND PROSTHETIST LICENSURE

PLEASE CONFIRM THAT THE FOLLOWING RESPONSES ARE CORRECT BEFORE SUBMITTING THIS FORM. INAPPROPRIATE ANSWERS WILL RESULT IN A DELAY IN PROCESSING THE APPLICATION.

Standard Questions

		Yes	No
1.	Have you ever received reports of poor clinical practice by this individual, or have you discussed concerns you had about this individual?	❑	❑
2.	Have you ever received reports of poor relationships between this individual and other members of the clinical staff?	❑	❑
3.	Are you aware of any derogatory information about this individual with respect to his/her ability to practice?	❑	❑
4.	Does this individual have, or has this individual had in the past, any mental or physical illnesses or personal problems that interfere with his/her practice?	❑	❑
5.	Has this individual ever abused alcohol or drugs or shown signs of chemical dependency?	❑	❑
6.	Are you aware of any lawsuits having to do with his/her practice, that this individual has either lost or settled out of court?	❑	❑
7.	Are you aware of any restrictions, limitations or other actions of any nature taken against this individual by a health related entity?	❑	❑

Personal Information

1. What type of device did this individual provide for you, or what did you receive?

_____

2. How long have you known this practitioner? _____
3. Please explain your relationship to this practitioner.

_____

_____

4. In what capacity has this person worked with you?

_____

5. Describe your experience with this person.

_____

_____

6. Would you refer someone to this practitioner for treatment? ____YES ____NO
7. Do you recommend this individual for unrestricted licensure in Georgia? ____YES ____NO

_____

SIGNATURE

_____

Phone Fax