GEORGIA COMPOSITE MEDICAL BOARD

2 Martin Luther King Jr. Drive SE East Tower, 11th Floor • Atlanta, GA 30334 • Tel: 404.656.3913 • FAX: 404.656.9723 http://www.medicalboard.georgia.gov E-Mail: gcmb.oandp@dch.ga.gov

APPLICATION INSTRUCTIONS FOR ORTHOTISTS & PROSTHETISTS LICENSURE

Please read these instructions and the laws governing the practice of orthotics and prosthetics before completing your application. The Board strongly encourages the use of our website at **www.medicalboard.georgia.gov** to download application information.

Orthotists and Prosthetists applications are good for **one-year only** from date of receipt. **APPLICATIONS WILL NOT BE REVIEWED WITHOUT APPLICATION FEE.**

NOTE: WE WILL DISCUSS APPLICATION STATUS WITH THE APPLICANT ONLY.

APPLICATION PROCESSING

Please include the application fee with your submission, as processing cannot commence without it. You will receive a status letter within 10 business days detailing any additional required documents. Promptly submit any outstanding materials. For inquiries about your application's status, please wait 10 business days post-submission or until you receive a deficiency letter before contacting staff. Note that the review process strictly adheres to State law, and staff cannot grant exceptions.

BOARD MEETINGS

To be considered for approval, your application must be fully completed and received at least 5 business days prior to the upcoming board meeting. An application is deemed complete once all primary source documents are reviewed, administrative screenings are passed, a final quality assurance check is done, and you have received written confirmation from the Board.

INTERNET DISCLOSURE OF ADDRESS

Georgia law requires the Georgia Composite State Board of Medical Examiners to provide, upon written or verbal request, an address for each licensed Orthotist or Prosthetist. Public-record information pertaining to licensed Orthotist or Prosthetist is available to the public through the Board's website (www.medicalboard.georgia.gov).

The release of this information has highlighted the need for individuals to carefully consider the address they provide to the Board as their address of record. The address you indicate as your address of record will be the address disclosed to all individuals making inquiries and will be utilized to mail all licenses, renewal notices, and other official correspondence from the Board.

You may choose your home address or your office address to be your address of record. If you list a P.O. Box as your primary address, you must also provide a secondary street address that will remain confidential. Georgia law requires that the Board be kept informed of any changes of address. Changes should be submitted in writing to the above address, and should include the license number, name, old address, and new address.

CHECKLIST FOR ORTHOTISTS & PROSTHETISTS

THIS CHECKLIST is intended to assist you with the filing of a complete application. Read all instructions on each page carefully and utilize the checklist as you are filling out the application. All items listed that apply to your situation must be submitted in order for your qualifications for licensure to be assessed. When submitting copies of documents, please ensure they **are 8-1/2 x11-inch copies** of the original. *Do not submit two-sided copies of the application or documentation*. **For quality and confidential purposes, facsimiles of application materials are not accepted. All application material must be original, unaltered, and official where required.**

MAKE YOUR CHECK OR MONEY ORDER PAYABLE TO Georgia Composite Medical Board*.* The FEE BELOW MUST ACCOMPANY THE APPLICATION OR THE APPLICATION WILL NOT BE PROCESSED. IF YOUR CHECK IS RETURNED FOR INSUFFICIENT FUNDS, APPLICATION PROCESSING WILL STOP. PROCESSING WILL RESUME ONCE THE OUTSTANDING FEES ARE RECEIVED.

PERMANENT LICENSE: ORTHOTIST OR PROSTHETIST

❑ **$300.00 (NON-REFUNDABLE FEE)**

DUAL CERTIFICATION: (ORTHOTIST and PROSTHETIST)

❑ **$400 (NON-REFUNDABLE FEE)**

LICENSURE REQUIREMENTS:

❑ **APPLICATIONS PAGES 1 – 6.** These pages must be completed in all areas.

❑ **SCHOOL TRANSCRIPT(S)**

Possess a **baccalaureate degree** from a college or university and completion of a program in prosthetics or orthotics that meets or exceeds the requirements, including clinical practice, of the Commission on Accreditation of Allied Health Programs (CAAHEP). You will need to contact your school to determine what information they need to send you a transcript of courses and grades that made up your education. The school should stamp across the back of the envelope with their school seal. When you receive this document, **do not open the** envelope. Send the unopened envelope with your application packet. **Altered envelopes which contain official, original, certified official documents will not be accepted.**

❑ Proof of completing a clinical residency in orthotics and/or prosthetics that meets or exceeds the standards and requirements for residencies of the National Commission on Orthotic and Prosthetic Education.

OR

Possess an **associate's degree** from a college or university with successfully completed courses in human anatomy, physiology, physics, chemistry and biology and have completed at least five (5) years of work experience in the discipline for which the license is sought, under the supervision of a practitioner licensed or certified in such discipline by an agency accredited by the National Commission for Certifying agencies. You will need to contact your school to determine what information they need to send you a transcript of courses and grades that made up your education. The school should stamp across the back of the envelope with their school seal. When you receive this document, **do not open the** envelope. Send the unopened envelope with your application packet. **Altered envelopes which contain official, original, certified official documents will not be accepted.**

❑ **FOR APPLICANTS WHO ARE NOT U.S. CITIZENS:**

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 following document(s):

1. Valid (not expired) foreign passport with I-94 or I-551
2. Temporary resident alien card (I-688)
3. Permanent resident alien card (I-551)
4. Employment Authorization Card (I-766) or (I-688A)
5. Employment Authorization Document (I-688B)
6. Refugee Travel Document (I-571)
7. Reentry Permit (I-327)
8. Certificate of Citizenship
9. Naturalization Certificate
10. Machine Readable Immigrant Visa (with Temporary I-551 Language)
11. Temporary I-551 Stamp (on passport of I-94)
12. I-94 (Arrival/Departure Record)
13. I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status)
14. DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

Please be sure that copies of any submitted documents are legible. Use a good quality copier and increase the size of the copy if need be. If the following information is needed, it must be legible: Alien Number; Card Number; Document Expiration Date; SEVIS ID Number. One or all of these numbers or dates may be required when we submit your information to SAVE. If we cannot read what you have submitted, we will be unable to submit your information to the SAVE program, which will delay the consideration of your application.

FORMS

❑ **FORM A - AFFIDAVIT OF APPLICANT**

Read this form in its entirety and complete all areas. **A current passport photo is required to complete this form.** Do not submit photos from digital reproductions, magazine, yearbook, wedding, birthday, family outing, etc. Take this form to a notary public for witness of your signature. **The applicant's signature date and the notary signature date must match. No whiteouts or strikeouts are accepted.**

❑ **Notarized Affidavit** that you are a United Stated Citizen, a legal permanent resident of the United States, or that you are a qualified alien or non-immigrant under the Federal Immigration and Nationality Act. If you are not a U.S. citizen, you must submit documentation that will determine if you have a qualified alien status. 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. If you are a qualified alien or non-immigrant under the Federal Immigration and Nationality Act, you must provide the alien number issued by the Department of Homeland Security or other federal immigration agency. **This Affidavit form may be found on our website as page 2 of Form A.** This form must be signed, dated and notarized.

❑ **Verifiable Document. Send along with your Notarized Affidavit, at least one secure and verifiable document. For a listing of acceptable verifiable documents, see Page 3 of Form A.**

❑ **FORM B - REFERENCE FORM**

The BOARD requires four **(4)** references. Formal letters of reference are not accepted in lieu of the Reference Form since questions on the form are required by the Board.
In addition, the reference forms must come from the following individuals:

a. **2 references from current or former patients from EACH discipline**.
b. 2 references from **referral sources (i.e., physicians, physical therapists, case managers, etc.)**
c. The Board **does not accept faxed copies of the reference form**.
   - Original signature and date of signature of reference source.
   - The date of the reference source's signature is invalid six months of the date it was signed.

(d) Please be specific of the type of orthoses or prosthesis provided or referred

❑ **FORM C - STATE BOARD LICENSE VERIFICATION**

Original official, certified verifications of license history of all licenses you have held or currently hold is required for each permanent, temporary, training, provisional or limited license held, even if you have not worked in that state or in any state in the US or Canadian territory or province, and US federal jurisdiction for 20 years, or you got a license and never practiced in that state. List the State/Country, dates of licensure, licensed by examination, reciprocity, or state board examination. **Copy this form and send it to each state licensing board and request that state verification be sent directly to the Board.**

❑ **FORM D - Verification from the American Board for Certification in Orthotics and Prosthetics, Incorporated (ABC).**

If certified by the American Board for Certification in Orthotics and Prosthetics, Incorporated (ABC) successful passing of ABC examination is required. Please complete **Form D** and mail to ABC. **All official documents must contain original seals** in order to be accepted by the board. **Request ABC to send this certification directly to the Board.**

REPORT REQUEST

❑ **HEALTHCARE INTEGRITY AND PROTECTION DATA BANK (HIPDB)**

This data bank is mandated by Congress to track regulatory Board disciplinary actions and certain actions resulting from peer review and malpractice payments. This is to advise that **you must self-query** the HIPDB on your own as part of the application process for a Georgia license. Simply query the data bank using the Internet address at www.npdb-hipdb.com, then click on Perform a Self-Query from the Quick List on the home page, or call 1-800-767-6732 from 8:30 am to 6:00 pm EST (8:30 to 5:30 on Fridays). When you receive the response, **do not open the envelope** – **send the envelope, unopened, directly to the Board along with your application packet. Altered envelopes which contain official, original, certified official documents will not be accepted**.

FORM A
AFFIDAVIT OF APPLICANT

PASSPORT PHOTO

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 Orthotist and Prosthetist 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 Orthotics and Prosthetics Practice Act, and the Board Rules.

I further state that by filing this application for license to practice orthotics and prosthetics in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to practice. 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 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 State Board of Medical Examiners.

I hereby swear or affirm under penalties of 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 false swearing may constitute a felony offense under O.C.G.A. 16-10-71. I understand that working and falsely presenting myself to the public as licensed to practice as an orthotist and/or prosthetist is a violation of the Orthotics and Prosthetics Act and is a misdemeanor.

SIGNATURE OF APPLICANT	DATE	CITY	COUNTY	STATE

PRINTED NAME OF APPLICANT	Being duly sworn, says that he/she is the person who executed the above application for a license to practice orthotics and prosthetics in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.	NOTARY SEAL MUST BE IMPRINTED HERE

Sworn and subscribed to me this _____day of _____, _____

_____(Notary Public)

My Commission Expires

_____

O.C.G.A. § 50-36-1(e)(2) Citizenship Affidavit for Medical Board License

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, from the Georgia Composite Medical Board, the undersigned applicant verifies **one** of the following with respect to my application for a public benefit:

___ 1. I am a United States citizen.

___ 2. I am a legal permanent resident of the United States.

___ 3. I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security.
My alien number issued by the Department of Homeland Security is: _____.

I am 18 years of age or older and have provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit. In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____(state).

_____ _____

SIGNATURE OF APPLICANT NAME OF APPLICANT (PRINT)

LICENSE TYPE (check one):

___ PHYSICIAN
___ PHYSICIAN ASSISTANT
___ RESPIRATORY CARE PROFESSIONAL
___ ACUPUNCTURIST
___ CLINICAL PERFUSIONIST
___ TEMPORARY RESIDENCY TRAINING PERMIT
__ ORTHOTIST AND/OR PROSTHETIST
___ COSMETIC LASER PRACTITIONER
___ GENETIC COUNSELOR
PAIN MANAGEMENT CLINIC
__ AURICULAR DETOXIFICATION SPECIALIST

___ OTHER (SPECIFY): _____

INSTRUCTIONS TO APPLICANT:

1. **Be sure to submit the correct type of document with this affidavit.** If you are not a citizen of the United States, you must submit a copy of a document we can use to verify your lawful presence, such as your U.S. Permanent Resident Card, foreign passport with I-94 attached, etc. If you are a U.S. citizen, you may submit a copy of your U.S. passport, driver's license, birth certificate, etc.

2. Scan and email **both** the notarized affidavit and a copy of at least ONE (1) secure and verifiable document to: **gcmb.oandp@dch.ga.gov**

SUBSCRIBED AND SWORN BEFORE ME ON THIS

_____ DAY OF _____, 20____

_____
NOTARY PUBLIC
My Commission Expires:

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2012 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Certification of Report of Birth issued by the United States Department of State (Form DS-1350) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Certification of Birth Abroad issued by the United States Department of State (Form FS-545) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Consular Report of Birth Abroad issued by the United States Department of State (Form FS-240) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- An original or certified copy of a birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

FORM B

REFERENCE FORM – ORTHOTIST AND PROSTHETIST LICENSURE FROM EACH DISCIPLINE

To Applicant: The GEORGIA COMPOSITE MEDICAL BOARD requires completion of FOUR **(4)** 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 email your form with your application packet to:

gcmb.oandp@dch.ga.gov

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

a. **2 references from current or former patients FROM EACH RESPECTED DISCIPLINE**. **Custom shoes, foot orthotics are/or knee braces are not accepted.**

b. **2 references 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 asthis.

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 FORM – 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

FORM C
LIC E NSE VERIFICATION

To be completed by the applicant. Original verification history of all licenses you have held or currently hold is required – even if you have not worked in that state for 20 years or you received a license and never practiced in that state. List the State/Country, dates of licensure, licensed by examination, reciprocity, state board examination. This form should be sent to each state in which you are now or ever have been licensed to practice. **This form may be photocopied.**

TO:_____Board

FULL NAME _____ STREET ADDRESS _____ APT. NO.

SIGNATURE _____ CITY _____ STATE _____ ZIP _____

The individual listed above has applied for licensure in Georgia. Before further consideration is given to this application, we need the information requested on this form. By signing this form, I give my consent to the release of any information, favorable or otherwise, for its review in considering me for licensure. Please mail the completed form as soon as possible to the Board at the address listed below.

Section II: This Section to be completed by an official of the above referenced Licensing Board.

Do not return this form to the applicant, but email it directly to: gcmb.oandp@dch.ga.gov

Title of License: _____ License number: _____

Original issue date: _____ Expiration date: _____

License status: [ ] Active [ ] Inactive [ ] Temporary [ ] Other

Licensure Method: [ ] Grandfathering [ ] Endorsement [ ] Examination

1. Has any disciplinary action ever been taken again this license? [ ] YES [ ] NO
   If YES, provide the board with any documentation regarding the disciplinary action.
2. Do you have derogatory information concerning this applicant? [ ] YES [ ] NO

_____ _____
Print Name Date

_____ _____
Signature Office Number

_____ _____
Title Fax Number

_____
State Board

BOARD SEAL MUST BE IMPRINTED HERE

FORM D
VERIFICATION OF EXAMINATION
RELEASE OF INFORMATION

AMERICAN BOARD FOR CERTIFICATION IN ORTHOTICS AND PROSTHETICS, INC. (ABC).

PLEASE SEND THIS FORM DIRECTLY TO THE AMERICAN BOARD FOR CERTIFICATION IN ORTHOTICS AND PROSTHETICS, INC. (ABC).

ORTHOTIST AND/OR PROSTHETIST: Please complete the top half of this form prior to mailing to the ABC.

Social Security Number: _____

Last Name	**First Name**	**Middle Initial**

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

The undersigned authorizes the **ABC** to release to the **Georgia Composite Medical Board (GCMB)**, the information requested below:

_____ _____
Applicant's Signature **Date Signed**

TO: GEORGIA COMPOSITE MEDICAL BOARD

As Registrar of the American Board for Certification in Orthotics and Prosthetics (ABC), I hereby attest that the above named applicant was certified by examination on _____and is currently certified by the Board until_____.

ABC Certificate #_____.

_____ _____
Signature **Date Signed**

COMMISSION SEAL

PLEASE EMAIL THIS FORM DIRECTLY TO:
gcmb.oandp@dch.ga.gov