

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**.

Please submit your form with your application packet to:

<https://gcmb.nextrequest.com/>

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 DISCIPLINE (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 prosthesis 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, date, and **email it directly to the Board**. 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. The processing time for licensure directly depends on timely receipt of critical forms such as this. Do **not** copy the applicant or any third party on the submission of this form to the Board.

Submit completed forms to <https://gcmb.nextrequest.com/> The applicant's name should be in the email subject line.

Submissions **MUST** come from a hospital/practice/work email address and directly from the person giving the reference. No personal emails (Gmail, Yahoo, etc.), and no emails addresses from others (practice managers or assistants) accepted.

ATTENTION. *The person who signs this form **MAY NOT** be related to the applicant by blood, marriage, or adoption.*

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever received reports of poor relationships between this individual and other members of the clinical staff? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you aware of any derogatory information about this individual with respect to his/her ability to practice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has this individual ever abused alcohol or drugs or shown signs of chemical dependency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you aware of any restrictions, limitations or other actions of any nature taken against this individual by a health related entity? | <input type="checkbox"/> | <input type="checkbox"/> |

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