## Order Form Duplicate Wallet ID Card Georgia Composite Medical Board 2 Peachtree Street, NW, 6<sup>th</sup> Floor Atlanta, GA 30303

## Return this completed form with the required fee to the address above:

Complete (print/type) form below. If you have both a mailing address and a practice address in our records, your mailing address will be printed at the top of your wallet identification card and your practice address will be printed on the bottom of your wallet identification card. If you do not provide us with a practice location, then your mailing address will display on your wallet identification card and on the website.

Submit this form with your payment of **\$25** by personal check, money order or cashiers check made payable to the <u>Georgia Composite Medical Board</u>. *Please allow 10 business days for delivery*.

Complete	e all informatio	on below:	
Is this a new or corrected name?	Yes No		
Name:		License	e No.:
License type (select only one type):		Amount enclo	sed: \$
Acupuncturist			
Clinical Perfusionist			
Cosmetic Laser Practitioner			
Genetic Counselor			
Orthotist			
Prosthetist			
Orthotist/Prosthetist Dual			
Physician			
Physician Assistant (including Anest	hesiologist Assis	stant)	
Resident Training Physician			
Respiratory Care Professional			
Pain Management Clinic			
Is this a new or corrected mailing address?	Yes	No	
Mailing Address:			
(Street	Address, inclu	uding suite/un	it number)
City		State	Zip
email address:	Telephon	Telephone number:	
Is this a new or corrected practice address?	Yes	No	
Practice Address:			
	Address, inclu	uding suite/un	lit number)
(00000	<b>-</b> , <b></b>	<u> </u>	
City		State	Zip
email address:	Telephon	e number:	
Revised: 9/4/2020			