ATTACH CHECK HERE

GEORGIA COMPOSITE MEDICAL BOARD

EFFECTIVE
JULY 1, 2001

ALL FEES ARE NONREFUNDABLE

Physician Assistant Application
ADD OR CHANGE SUPERVISING PHYSICIAN

You may not begin work with a new or additional supervising physician without written notice of approval. **Georgia State Government or Georgia County employees are fee exempt** Federal government employees are not exempt).

NOTE: AN ALTERNATE SUPERVISOR DOES NOT AUTOMATICALLY BECOME YOUR NEW SUPERVISING PHYSICIAN. YOU MUST SUBMIT A NEW APPLICATION WITH YOUR NEW PRIMARY SUPERVISOR.

Physician Assistant 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 _____

Gender □ Male □ Female

License #:_____

Birth Date (mm/dd/yy) ____/____/____ **DEA #:**_____

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: 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 location!!

Street Number Street Name City State Zip Suite/Bldg

Area Code Phone Number

Email:_____@_____

REVISED: 01/2024

Utilization of Physician Assistant or Anesthesiologist Assistant

Provide information for the Physician(MD/DO) requesting utilization of PA/AA.

PA/AA Name: _____

Physician GA License Number: _____

Physician First Name: _____

Physician Middle Name: _____

Physician Last Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Business Phone: _____

Specialty: _____

***If specialty is Pain Management, please refer to pain management rules and regulations for additional requirements REQUIRED to practice.

Type of Primary Practice Setting (clinic, hospital, ER/Urgent care, Telemedicine, etc):

_____

Telemedicine Practice: Yes_____ No_____ If you checked "yes":

Please provide the physical address in which the PA will be using to provide Telemedicine services.

_____

_____