Pain Clinic License#: _____

# PAIN MANAGEMENT CLINIC RENEWAL APPLICATION

## OFFICE INFORMATION (TYPE OR PRINT LEGIBLY)

Name of Pain Clinic **Registered** with the Board:

_____

Federal Tax Identification Number (FEI#) OR Employer Identification Number:

_____

**Pain Management Clinic Physical Address *(P.O. Boxes are not acceptable)***

_____
(Street) (Suite #)

_____
(City) State (Zip Code) (County)

**Pain Management Clinic Mailing Address (where correspondence will be sent)**

_____
(Street) (Suite #)

_____
(City) State (Zip Code) (County)

Pain Management Clinic Telephone Number: _____

Pain Management Clinic Fax Number: _____

Pain Management Clinic Email Address: _____

1. Type of Ownership: ☐ Individual ☐ Partnership ☐ Corporation

2. Percentage of Ownership by Georgia physician: _____

   If you are **NOT** 100% physician owned, circle below to indicate which exemption you fall under.

   A. Pain management clinic **jointly owned** by one or more physician assistants or advanced practice registered nurses and one or more physicians?

   B. Pain management clinic **NOT majority owned** by physicians licensed in this state?

3. State of Incorporation_____
   (If Applicable)

## OFFICE INFORMATION (CONT)

For inspection purposes, list the Business Operating Hours for this clinic.

**Business Operating Hours:**

| Day | Open | Close |
|---|---|---|
| Monday | ____:____ ◯AM ◯PM | ____:____ ◯AM ◯PM |
| Tuesday | ____:____ ◯AM ◯PM | ____:____ ◯AM ◯PM |
| Wednesday | ____:____ ◯AM ◯PM | ____:____ ◯AM ◯PM |
| Thursday | ____:____ ◯AM ◯PM | ____:____ ◯AM ◯PM |
| Friday | ____:____ ◯AM ◯PM | ____:____ ◯AM ◯PM |
| Saturday | ____:____ ◯AM ◯PM | ____:____ ◯AM ◯PM |
| Sunday | ____:____ ◯AM ◯PM | ____:____ ◯AM ◯PM |

4. Person to be contacted for communication, or notice and citation matters:

Name: _____ Title: _____

Address: _____

Phone #: (_____) _____- _____

EMAIL ADDRESS: _____

5. Do you intend to dispense drugs in accordance with Georgia Rules and Reg. 480-28?

If yes, please indicate what type(s) of drugs you wish to dispense:
Check all that apply:

☐ Prescription Drugs (Other than controlled substances)

☐ Controlled Substances

Practitioners who intend to dispense drugs must notify the Georgia Composite Medical Board in writing and comply with all Board of Pharmacy laws and rules.
See O.C.G.A. 26-4-130 and Rule Chapter 480-28.

# PAIN MANAGEMENT CLINIC <u>OWNERSHIP</u> INFORMATION

**TYPE OR PRINT LEGIBLY.** List the information pertaining to all pain management clinic owner(s). **NOTE:** IF YOU HAVE MORE THAN THREE OWNERS, **copy this sheet to list the additional owners.**

**1.**

| **Owner Name:** | **License Number/Profession:** |
|---|---|
| Address: | |
| Telephone Number: | |
| DEA Number: | Email Address: |

**2.**

| **Owner Name:** | **License Number/Profession:** |
|---|---|
| Address: | |
| Telephone Number: | |
| DEA Number: | Email Address: |

**3.**

| **Owner Name:** | **License Number/Profession:** |
|---|---|
| Address: | |
| Telephone Number: | |
| DEA Number: | Email Address: |

# PAIN MANAGEMENT CLINIC "OTHER" OWNERSHIP INFORMATION

**TYPE OR PRINT LEGIBLY.** List the information pertaining to all pain management clinic principal(s), officer(s), agent(s), AND/OR managing employee(s). **NOTE:** IF YOU HAVE MORE THAN ONE OF EACH CATEGORY, **copy this sheet to list the additional information.**

| **PRINCIPAL NAME:** | **License Number/Profession:** |
|---|---|
| Address: | |
| Telephone Number: | |
| DEA Number: | Email Address: |

| **OFFICER NAME:** | **License Number/Profession:** |
|---|---|
| Address: | |
| Telephone Number: | |
| DEA Number: | Email Address: |

| **AGENT NAME:** | **License Number/Profession:** |
|---|---|
| Address: | |
| Telephone Number: | |
| DEA Number: | Email Address: |

| **MANAGING EMPLOYEE NAME:** | **License Number/Profession:** |
|---|---|
| Address: | |
| Telephone Number: | |
| DEA Number: | Email Address: |

# PAIN CLINIC RENEWAL QUESTIONNAIRE

| | **If you answer YES to questions 1-3, provide written explanation and supporting documentation.** | YES | NO |
|---|---|---|---|
| | **SINCE THE <u>INITIAL</u> LICENSURE OF THIS PAIN CLINIC:** | | |
| 1. | Has the clinic license been revoked or otherwise disciplined by this Board? | ☐ | ☐ |
| 2. | Has any licensing Board or other state or federal agency taken a **public or private** disciplinary action against the clinic? | ☐ | ☐ |
| 3. | Has the clinic been, or currently the subject of an investigation by any licensing Board or other state or federal agency? | ☐ | ☐ |
| 4. | Has the clinic obtained a current Business License? | ☐ | ☐ |
| 5. | Has the clinic confirmed that all physician owners and practicing physicians are registered with the Georgia Prescription Monitoring Program ("PDMP") to regularly check the PDMP on all new and existing patients? | ☐ | ☐ |
| 6. | Has the clinic confirmed that all physician owners and all practicing physicians are in compliance with the continuing education requirements for renewal of the pain clinic license? **NOTE: Each physician owner and practicing physician will be required to show proof of continuing education.** | ☐ | ☐ |
| 7. | Is the clinic aware of the **revised** rule 368-8-.05 regarding Notifications to the Board? | ☐ | ☐ |
| 8. | Is the clinic aware that the Board may inspect the clinic at any time to verify that the necessary medical equipment to provide the medical treatment or services offered comply with sanitation standards? | ☐ | ☐ |

I acknowledge and state that I have read the 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 Medical Practice Act and the Board Rules. This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that pursuant to the Official Code of Georgia Annotated, Section 43-34-46, any person who shall give false or forged evidence of any kind to the Board in connection with an application shall be guilty of a felony and upon conviction thereof, shall be punished by a fine of not less than $500.00 nor more than $1,000.00, or by imprisonment from two to five years, or both.

_____ _____

Owner Name Owner Signature

_____

Date

# PHYSICIAN INFORMATION

TYPE OR PRINT LEGIBLY: Complete the section below for **EACH physician owner and each** practicing physician who is currently **approved** to work at the pain clinic. The **physician owner and practicing physician** must also answer and attest to the questions listed below. If you have more than one physician owner and practicing physician working in your pain clinic, copy this page and complete the information for EACH physician.

| |
|---|
| **Physician Name:** |
| License Number/Profession: |
| Address: |
| Telephone Number: |
| DEA Number: Email Address: |

**1.** Does the practicing physician listed above currently work at any other pain clinic? ☐ **YES** ☐ **NO**

**A.** If Yes, list pain clinic name: _____

If yes, list Pain Clinic Location: _____

If yes, list pain clinic hours: _____

**2.** Have you attached evidence of having obtained during the preceding two (2) years, twenty (20) hours of continuing medical education ("CME") pertaining to **pain management or palliative medicine?**. Such CME **must be** an AMA/AOA PRA Category 1 CME, a board approved CME program, or any federally approved CME. ☐ **YES** ☐ **NO**

## OR

Have you attached evidence of current certification or eligibility for certification in **pain management or palliative medicine** as approved by the Board? The Board recognizes certifications in pain medicine or palliative medicine by the American Board of Medical Specialties or the America Osteopathic Association, the American Board of Pain Medicine and the American Board of Interventional Pain Physicians.
☐ **YES** ☐ **NO**

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_____ _____

Printed Name of Physician

_____

Signature of Physician

# CERTIFICATION FORM

INSTRUCTIONS:

The certification form is on pages 7-9 and should be completed by each **OWNER and PRACTICING PHYSICIAN** named in the renewal application.

All information requested on this form is mandatory for the purpose of a criminal history record check. Failure to provide any and all of the requested information will result in an incomplete background investigation and rejection of the application. This information will be used to determine your qualifications to work in a pain clinic. This information may be shared with other government agencies upon receipt of an official request.

**NAME:** _____

**SEX:** _____**MALE** _____**FEMALE** **RACE:** _____

**STREET ADDRESS:** _____

_____

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

**DATE OF BIRTH:** _____

**SOCIAL SECURITY NUMBER:** _____

**TELEPHONE:** _____

**FAX:** _____

**PAIN CLINIC NAME:** _____

**Position with the Pain Clinic: (Check all that apply)**

☐ **Owner** ☐ **Practicing Physician**

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed. The undersigned hereby authorizes the Georgia Composite Medical Board to conduct an inquiry for the purpose of employment and receive any Georgia and/or national CHRI as authorized by state and federal law.

Print Name: _____

Applicant Signature: _____

Date: _____

# OWNER/PRACTICING PHYSICIAN QUESTIONNAIRE

| | **EACH OWNER AND PRACTICING PHYSICIAN MUST COMPLETE THIS QUESTIONNAIRE. ALL YES ANSWERS MUST BE SUPPORTED WITH DOCUMENTATION AND EXPLANATION, WHERE APPLICABLE.** | **YES** | **NO** |
|---|---|---|---|
| 1. | Are you a US Citizen? If NO, you must submit documentation to verify your citizenship status. | ☐ | ☐ |
| 2. | Since the clinic was licensed have you suffered from any physical, psychiatric, or substance use disorder that could impair or require limitations on your functioning as a professional or has resulted in the inability to practice for more than 30 days, or required court-ordered treatment or hospitalization? (If yes, provide treatment history documentation to include diagnosis, treatment regimen, hospitalization, and ongoing treatment/medication to the Board) | ☐ | ☐ |
| 3. | Since the clinic was licensed have you been convicted of a felony, entered a plea bargain, been arrested, indicted or convicted for violating any state or federal law including DUI (excluding minor traffic violations)? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding, or the affording of Frist Offender Treatment, regardless of whether the adjudication of guilt or sentence is withheld or not entered. If yes, provide a personal narrative of the circumstances surrounding the incident and include a copy of the charges, plea or jury verdict, and final disposition, sentence, probation, and payment of fines | ☐ | ☐ |
| 4. | Since the clinic was licensed has any licensing Board or other state or federal agency ever taken a **public or private** disciplinary action against you? | ☐ | ☐ |
| 5. | Since the clinic was licensed have you ever been refused renewal of a certificate or a license by any licensing Board or other state or federal agency? | ☐ | ☐ |
| 6. | Are you currently registered with the DEA? | ☐ | ☐ |
| 7. | Is your DEA license currently active?<br><br>If yes, provide DEA#_____<br><br>Date of expiration:_____ | ☐ | ☐ |
| 8. | Since the clinic was licensed have you been denied a DEA registration number? | ☐ | ☐ |
| 9. | Since the clinic was licensed have you been issued a restricted DEA registration? | ☐ | ☐ |
| 10. | Since the clinic was licensed have you surrendered a DEA registration or controlled substance registration? | ☐ | ☐ |
| 11. | Since the clinic was licensed, have you had your federal registration to prescribe, distribute, or dispense controlled substances suspended or revoked? | ☐ | ☐ |
| 12. | Since the clinic was licensed have you been convicted of a crime under any state or federal law relating to any controlled substance? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding or the affording of First Offender Treatment, regardless of whether the adjudication of guilt or sentence is withheld or not entered. | ☐ | ☐ |
| 13. | Since the clinic was licensed have you surrendered a medical license? | ☐ | ☐ |

| | OWNER/PRACTICING PHYSICIAN QUESTIONNAIRE - (con't) | YES | NO |
|---|---|---|---|
| 14. | Since the clinic was licensed have you been, or currently the subject of an investigation by any licensing Board or other state or federal agency? | ☐ | ☐ |
| 15. | Since the clinic was licensed have you had any restrictions or been terminated as a Medicaid or Medicare provider in any state? If yes, provide documentation to indicate that you were reinstated and in good standing with the Medicaid Program. | ☐ | ☐ |
| 16. | Are you currently in default on child support payments? | ☐ | ☐ |

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_____

Printed Name

_____

Signature of Physician Owner/Practicing Physician

_____

Date