ATTACH CHECK HERE

GEORGIA MEDICAL BOARD (GMB) USE ONLY

AP NUMBER		**FILE NUMBER**	
RECEIVED		**COMPLETED**	
TEMP LICE NO		**DATE ISSUED**	
LICENSE NUMBER		**DATE ISSUED**	
WITHDRAWN		**DATE WITHDRAWN**	
DENIED		**DATE DENIED**	

ALL FEES ARE NONREFUNDABLE* FEES ARE SUBJECT TO CHANGE

☐ **Check here if you are fee exempt (Georgia State Government or Georgia County employees are fee exempt** Federal government employees are not exempt) **and list your exempted facility** in the space below:

_____

REINSTATEMENT APPLICATION - PHYSICIAN'S ASSISTANT

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, U.S.C.A. 651 and 20 U.S.C.A. 1001. This information also may be disclosed to the National Practitioner's Data Bank (NPDB) or other state medical boards or regulatory agencies for license tracking purposes. If you do not wish this information to be released to the NPDB or other medical boards or other regulatory agencies for license tracking purposes, please check here: _____

1. LAST NAME	FIRST NAME	MIDDLE NAME	
MAIDEN NAME	SEX M F	DATE OF BIRTH (MM/DD/YY)	Social Security Number
☐ **I am a U.S. Citizen** ☐ **I am not a U.S. Citizen, but am a qualified alien under the Federal Immigration and Naturalization Act, and I am lawfully present in the United States. (IF YOU CHECKED THIS BOX, SEE CHECKLIST REQUIREMENTS FOR SUBMITTING SUPPORTING DOCUMENTATION)**			
2. Mailing address – This address will be used for all official communications from the Georgia Medical Board.			
STREET NUMBER STREET NAME			APARTMENT #
CITY	STATE	ZIP CODE	COUNTY
			@
(AREA CODE) PHONE NUMBER		(AREA CODE) FAX NUMBER	E-MAIL ADDRESS
3. Practice street address – In addition, this address will be publicly available on our website.			
STREET NUMBER STREET NAME			SUITE #
CITY	STATE	ZIP CODE	COUNTY
	( )		( )
	(AREA CODE) PHONE NUMBER		(AREA CODE) FAX NUMBER (OPTIONAL)

4. List all states in reverse chronological order that you are/have been licensed to practice as a PA by virtue of a certification issued by another duly constituted licensing Board in the United States as follows: If you require additional space, please download the "Additional States" Form located on our website at www.medicalboard.georgia.gov

State	Date Licensed	License Number	Licensure Status Active/Inactive)

5. **Have you ever taken the NCCPA Exam? _____Yes _____No (please circle one)**

   Date of Last Exam:_____

6. **Are you currently certified by the NCCPA? _____Yes _____No (please circle one)**

   Certificate #:_____

7. **Have you ever taken the NCCAA exam? _____Yes _____No (please circle one)**

   Date of Last Exam:_____

8. **Are you currently certified by the NCCAA? _____Yes _____No (please circle one)**

   Certificate #:_____

PHYSICIAN'S ASSISTANT
APPLICANT QUESTIONNAIRE

	IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO ATTACH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON, AND DISPOSITON OF THE MATTER (INCLUDE COPIES OF COURT ORDERS OR MALPRACTICE SUITS IF APPLICABLE) AND MAIL THIS FORM WITH APPROPRIATE DOCUMENTS DIRECTLY TO THE GEORGIA MEDICAL BOARD.	YES	NO
1.	Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years? (Provide the Board with all treatment history documentation to include diagnosis, treatment regimen, medical regimen, hospitalization, and on-going treatment/medication.)	___	___
2.	Have you ever been convicted of a violation of any National, Federal (including military) State or local Statute?	___	___
3.	Have you ever been denied the privilege of taking an examination by any State licensing board or been denied a certificate/licensure, or refused renewal of a certificate or license by any licensing board or agency?	___	___
4.	Has any state licensing board revoked, suspended a license issued to you or otherwise sanctioned your license?	___	___
5.	Are you currently registered with the DEA? If yes, provide the number and state of issue below: DEA Number _____ State of issue_____	___	___
6.	Have you ever been named as a party in a malpractice suit, arbitration hearing, military review, State Review panel proceeding, or VA/federal agency review?	___	___
7.	Have you ever had your hospital privileges limited, denied or revoked?	___	___
8.	Have you ever relinquished your hospital privileges?	___	___
9.	Have you ever voluntarily surrendered a DEA registration?	___	___
10.	Have you ever voluntarily surrendered your PA certificate/license?	___	___
11.	Do you have any applications for licensure pending before any other licensing Board or agency?	___	___
12.	Have you ever had any restrictions as a Medicaid or Medicare provider?	___	___
13.	To your knowledge, are you the subject of an investigation by any licensing Board or any other agency as of the date of this application?	___	___
14.	Have you ever defaulted on a state or federally funded and/or guaranteed school loan?	___	___
15.	Have you ever defaulted on child support payments?	___	___
16.	Have you served in the armed forces? If yes, please provide copy of DD214.	___	___

APPLICATION FOR UTILIZATION OF PHYSICIAN'S ASSISTANT

Please print legibly:

1. PHYSICIAN NAME: _____
(First) (Middle) (Last) (Degree)

2. BUSINESS ADDRESS: _____
(Street Address) (Business Telephone)

_____
(City) (State) (Zip Code)

3. PHYSICIAN SPECIALTY_____ **GA LICENSE NUMBER**_____

4. LIST CURRENT BOARD CERTIFICATIONS:_____

_____

5. NAME OF PROPOSED PHYSICIAN'S ASSISTANT & CURRENT ADDRESS:

Name: _____**DEA No.:** _____
(Last) (First) (Middle)

Address: _____
(Street Address)

_____
(City) (State) (Zip Code)

6. Type of Practice and Proposed Setting:

_____

_____