



PROFILE UPDATE AND CORRECTION FORM

2 Peachtree Street, N.W., 36th Floor ♦ Atlanta, GA 30303

PHONE (404) 651-7854 ♦ FAX (404) 656-9858

You may also make corrections to your profile at our website:

www.gaphysicianprofile.org

DATE: _____

NAME: _____ LICENSE # _____

PRACTICE ADDRESS: _____

The physician may request a copy of the profile and may submit corrections to the Board. The Board shall verify corrections and make changes to the profile within five business days of receipt of the corrected information.

A judgment, award, settlement, revocation, resignation, or disciplinary action shall be reported by the physician to the Board within ten days of such event. The board shall update the physician profile with such changes within ten days of receipt of such information. A copy of the award, settlement, revocation, or disciplinary must be mailed to the Board with this form. **The physician cannot update information regarding these items via the website.**

All other changes to the physician profile shall be reported by the physician to the Board within 30 days of the change, and the Board shall verify and update the physician profile with such new information within 15 days. The physician can update information regarding such items by mail or by visiting www.gaphysicianprofile.org and logging in with his/her user ID and PIN.

INSTRUCTIONS

If you are using this form to update information in your physician profile, please select the sections from the gray areas identified on your profile. Provide a detailed explanation of the inaccuracy and/or change. If the space provided is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate questionnaire item.

Physician Name: _____ License Number: _____

Physician Data

Medical Education and Training

Graduate Medical Education

Specialty Board Certifications

Physician Name: _____ License Number: _____

Current Hospital Staff Privileges

Final Disciplinary Actions

Criminal Offenses

Medical Malpractice Judgment Arbitration Awards

Physician Name: _____ License Number: _____

Medical Malpractice Settlements

Optional Information Limited to Most Recent Ten Years

Physician Comments

I swear or affirm that the statements that I have entered are true and correct and that I understand that my profile may be selected for verification of the information provided. I recognize that providing false information or incomplete information may result in disciplinary actions against my license pursuant to O.C.G.A. §§ 43-1-19 and 43-34-37 and may result in criminal penalties.

Signature of Physician

Date