



ATTACH
CHECK HERE

GEORGIA COMPOSITE MEDICAL BOARD
EFFECTIVE
JULY 1, 2001
ALL FEES ARE NONREFUNDABLE

Physician Assistant REINSTATEMENT Application
Be sure to review the application checklist before submitting your application.

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.

Check here if you would like to request a temporary license upon completion of your application

Social Security Number _____

Last Name (Surname) _____

First _____

Middle _____

Other Surnames _____

Gender Male Female

Birth Date (mm/dd/yy) _____ / _____ / _____

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



PHYSICIAN ASSISTANT APPLICANT QUESTIONNAIRE

	<p>IF YOU ANSWER “YES” TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO ATTACH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON, AND DISPOSITION 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.</p>	YES	NO
1.	Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? NOTE: If you are currently enrolled in GAPHP, you may answer NO.	—	—
2.	Have you 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, regardless of whether the adjudication of guilt or sentence is withheld or not entered.	—	—
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 licensing Board or agency ever taken a public or private disciplinary action against you?	—	—
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?	—	—



		YES	NO
13.	Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	—	—
14.	Have you ever defaulted on child support payments?	—	—
15.	Have you served in the armed forces? If yes, please provide copy of DD214.	—	—
16.	Are you a Georgia state employee? If yes, enter the Facility Name: _____	—	—
17.	Are you a Georgia county employee? If yes, enter the Facility Name: _____	—	—
18.	Have you ever taken the NCCPA Exam? If yes, enter date of Last Exam: _____ (MM/DD/YYYY)	—	—
19.	Are you currently certified by the NCCPA? If yes, enter Certificate #: _____	—	—
20.	Have you ever taken the NCCAA exam? If yes, enter date of Last Exam: _____ (MM/DD/YYYY)	—	—
21.	Are you currently certified by the NCCAA? If yes, enter Certificate #: _____	—	—
22.	Are you a U.S. Citizen? (If no, please refer to the applicant checklist listed on our website for acceptable documentation). If you are not a U.S. citizen, you must submit documentation that will determine if you have a qualified alien status. Only those applicants who can provide proof will be granted a license. The Board participates in the DHS-USCIS SAVE (Systematic Alien Verification for Entitlements or "SAVE") program for the purpose of verifying citizenship and immigration status information of non-citizens. In order to confirm your status with the SAVE program, you need to provide the board with legible copies of one of the documents listed on our website.	—	—
23.	Have you been practicing prior to reinstating your application?	—	—



License History

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:

State	Date Licensed From (mm/dd/yyyy)	Date Licensed To (mm/dd/yyyy)	License Number	Licensure Status Active/Inactive)

College Education Information

List name and location of college attended and date of attendance/graduation date.

School Name	From (mm/dd/yyyy)	To (mm/dd/yyyy)	City, State	Graduation Date (mm/dd/yyyy)



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.
