FORM A
AFFIDAVIT OF APPLICANT

I acknowledge and state that I have read and am familiar with the Physician Assistant Act and rules pertaining thereto. I further state that by filing this application for licensure as physician assistant in the State of Georgia; I authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to practice as a P.A. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state Federal or foreign) court, association, institution or any other organization having control of any documents, records or other such information pertaining to me, to furnish to the Georgia Composite Medical Board any such documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and permit the Georgia Composite Medical Board or any of its agents or representatives to inspect and make copies of such documents, records or other information, in connection with this application, subsequent to practice thereunder.

I hereby release, discharge, and exonerate the Georgia Composite Medical Board for any and all liability of every nature and kind arising out of the furnishing or inspections of such documents, records or other information or any investigation made by the Georgia Composite Medical Board to release information, material, documents, orders or the like relating to me or to this application to any other agency or any other agency of the State of Georgia, the medical licensing agency of any other state or territory of the United States, or Province of Canada, the Federation of State Medical Boards, or the U.S. Inc. law enforcement agency, hospital or other appropriate agencies as determined by the Board.

I hereby swear or affirm under penalties of perjury that all statements made by me in this application and any attachments hereto and made a part hereof are true and correct. I understand that pursuant to the Official Code of Georgia Annotated. Section 43-43-46 and 43-1-19(a)(2), 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 paying a fine or not less than $500.00 nor more than $1,000.00 or by imprisonment from two to five years or both. False swearing may constitute a felony offense under O.C.G.A. § 16-10-71. I understand that working with a Physician Assistant license and falsely presenting myself to the public as a licensed physician is a violation of the Physician Assistant Act and the Rules of the Georgia Composite Medical Board.

Photo 2" x 2"
Head & Shoulders

_____
Signature of Applicant **Date**

County_____ **State**_____

_____
Name of Applicant

_____
City and State

Being duly sworn and says, that he/she is the person who executed the above application; and that all statements herein contained are true and that the attached photograph is a true likeness of the applicant not more than six (6) months prior to the application date.

Sworn and subscribed before me this ____

Day of _____, _____.

Notary Public_____ **SEAL**