Name:_____ SS#:_____

FORM A
Affidavit of Applicant for Auricular Detoxification Technician

I acknowledge and state that I have read and am familiar with the Acupuncture Act and rules pertaining thereto. I further acknowledge that I have read and am familiar with the section of the Medical Practice Act and rules regarding the unlicensed practice as an Auricular Detoxification Technician. By filing this application for licensure as a Auricular Detoxification Technician 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 an Auricular Detoxification Technician. 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 understand that it is my personal responsibility to keep the Georgia Composite Medical Board informed of my employment and obtain prior permission for a change-of-employment where required by the Acupuncture Act or the rules of the Georgia Composite Medical Board. I also understand that it is my responsibility to keep the Medical Board informed of any change-of-address so that I may receive renewal notices and other correspondence from the Board.

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 to knowingly make any misleading, deceptive, untrue, false or fraudulent statement in obtaining a license, violates O.C.G.A. § 43-34-46 and 43-1-19-(a)(2). I understand that making any false sworn statements to the Board may constitute the felony offense of false swearing under O.C.G.A. § 16-10-71. I also understand that practicing acupuncture or auricular detoxification therapy without a license and falsely presenting myself to the public as licensed to practice violates O.C.G.A. 43-34-71 and 72.

CURRENT PHOTOGRAPH

APPROXIMATE SIZE 2" X 4"

_____
Print Name of Applicant

_____
Signature of Applicant **Date**

_____
City **County** **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 Photo is a true photo of the applicant.

Sworn and subscribed before me this ____day of _____, in the year _____.

Notary Public_____My Commission Expires:_____.

_____
Notary Name **Date**