FORM B11 RESPIRATORY CARE REFERENCE FORM

To be completed by Prospective Employer:

In order for the Georgia Composite Medical Board to adequately evaluate the applicant named below for certification to practice as a Respiratory Care Practitioner in the State of Georgia, please complete all pertinent sections in detail. This reference form will must be completed and signed by a **licensed physician** with whom the **applicant intends to practice.** This form must be mailed **directly from the physician to** the Georgia Composite Medical Board to the address listed below. An original signature is required for the licensed physician.

Georgia Composite Medical Board Respiratory Care Professional Unit 2 Peachtree Street, N.W. – 36th Floor Atlanta, GA 30303

I hereby certify that	will be employed under my
supervision as a Health Care Professional in Re	espiratory Care effective/
Applicant will work: \Box full time \Box part tim	e, approximately hours per week.
Additional Comments:	
Physician Name:	
<u>plea</u>	se type or print
Physician Signature:	Date:
(Original signatu	ire required)
License Number:	State:
Business Name:	
Mailing Address:	
City State	Zip Code
Business Telephone Number:	