

**FORM C**  
**STATE BOARD LICENSE VERIFICATION**

**INSTRUCTIONS:** Applicants with out-of-state certification are to complete Part 1 and of this form and mail to the **issuing** State Certification Board. Part 2 of the form should be complete by the State Certifying Agency.

**PART 1: To be completed by the applicant.**

TO: \_\_\_\_\_ Board of Examiners

**I am applying for a Georgia Auricular Detoxification Technician license. The Georgia Composite Medical Board requires your Board to complete this form in order that my application for licensure may be considered. By signing this form, I give my consent to the release of any information, favorable or otherwise, for its review in considering me for licensure. Please mail the completed form as soon as possible to the Board at the address listed below.**

FULL NAME	STREET ADDRESS, APT. NO.	CITY	STATE	ZIP CODE
LICENSE #	ISSUED	EXPIRES		

**PART 2: This Section To Be Completed By An Official of The Above Referenced Licensing Board.  
Do Not Return This Form To the Applicant, but mail it directly to:**

**Georgia Composite Medical Board  
ATTN: AURICULAR DETOXIFICATION  
2 Peachtree Street, NW - 36th Floor  
Atlanta, Georgia 30303**

- |  |                          |     |                          |    |
|--|--------------------------|-----|--------------------------|----|
| 1. Is the above individual currently certified in your state?                                    | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2. What was the total number of hours in training? _____   |                          |     |                          |    |
| 3. Was this person required to take an exam? If so, name the exam: _____                         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4. Has this license ever been revoked, suspended, denied or otherwise disciplined by your state? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5. Has the above individual ever been convicted of a felony?                                     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6. Do you know of any reason why certification should be denied?                                 | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Name of verifying person:

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency Name

\_\_\_\_\_  
Agency Phone Number