# FORM C
# VERIFICATION OF LICENSURE/CERTIFICATION

INSTRUCTION: The State Regulatory Agency in each State which you hold or ever held a license to practice must complete this form and send directly to the Georgia Composite Medical Board.

NAME OF APPLICANT: _____

LICENSE NUMBER: _____

PROFESSION IN WHICH LICENSE/CERTIFICATE WAS ISSUED: _____

NAME OF STATE ISSUING LICENSE/CERTIFICATE: _____

DATE ISSUED:_____ CURRENT:_____ NOT CURRENT:_____

IF NOT CURRENT, PLEASE PROVIDE EXPLANATION: _____

_____

DATES OF DISCIPLINARY ACTION (IF APPLICABLE):_____

REASON FOR DISCIPLINARY ACTION:_____

_____

LICENSE ISSUED ON THE BASIS OF:_____

I HEREBY CERTIFY THAT THIS INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND THAT BASED ON RECORDS AVAILABLE TO ME, THE APPLICANT WAS COMPETENT TO PRACTICE WHILE LICENSED/CERTIFIED IN THIS STATE.

_____
NAME OF OFFICIAL OF AGENCY

_____
ORIGINAL SIGNATURE

_____
TITLE

_____
DATE

**(SEAL)**

**PLEASE RETURN THIS FORM TO:**

**Georgia Composite Medical Board**
**2 Peachtree Street, N.W., - 36th Floor**
**Attn: Clinical Perfusionist Licensure**
**Atlanta, GA 30303**