

FORM G1
SPECIFIC POWER OF ATTORNEY
REINSTATEMENT PHYSICIAN LICENSURE

I, _____, do hereby authorize and direct _____ and its agents and employees, by this Specific Power of Attorney to carry out and execute certain duties pursuant to my request and necessary in _____'s reasonable judgment in connection with my pursuit of a license to practice medicine in the State of Georgia ("Licensed State").

It is expressly understood and agreed that this Specific Power of Attorney authorizes _____ to make inquiries as to the status of my application for a medical license in the Licensed State. This Specific Power of Attorney does not authorize _____ to act on my behalf for any other purpose and shall expire on the date I am granted a license in the Licensed State, the date my application for a medical license is denied, or upon _____'s receipt of written notice from me of revocation of this Specific Power of Attorney.

I hereby release _____ and the Licensed State from any and all liability, damages, claims for damages, suits, actions and causes of action which may accrue as a result of _____ acting on my behalf in connection with my pursuit of a medical license in the Licensed State.

PRINTED NAME OF APPLICANT _____ SIGNATURE OF APPLICANT _____	Being duly sworn, says that he/she is the person who executed the above application for a license to practice medicine and surgery in the State of Georgia; and that all the statements herein contained are true in every respect.	NOTARY SEAL MUST BE IMPRINTED HERE
Sworn and subscribed to me this ____ day of _____, _____ _____ _____ (Notary Public)	My Commission Expires _____	