NAME:_____ SS#:_____

PRINT LEGIBLY

FORM A
Temporary Postgraduate Training Permit
AFFIDAVIT OF APPLICANT

TOP OF PHOTO (HEAD)

PHOTO AREA
PASTE A 2 ¼" X 3"
PHOTO HERE.

PHOTO MUST BE OF
YOUR HEAD
AND SHOULDER AREAS ONLY

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided would be used to determine your qualifications for a temporary postgraduate training permit per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other medical licensing authorities the Federation of State Medical Boards or other governmental or law enforcement agencies.

I acknowledge and state that I have read the Application for Temporary Postgraduate Training Permit Information and Applicant Instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Medical Practice Act and the Board Rules, copies of which are sent to applicants.

I further state that by filing this application for a temporary postgraduate training permit to practice medicine in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation, and fitness for the practice of medicine. 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 request and authorize any treatment program to release alcohol and drug abuse patient records to the Georgia Composite Medical Board for the purpose of evaluating my fitness to practice. The consent of this paragraph is subject to revocation pursuant to federal regulations and terminates upon the date of termination of my training permit in Georgia.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or International), court, association, institution, or other organization having control of my documents, records and other information pertaining to me, to furnish to the Georgia Composite Medical Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Composite Medical Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice there under.

I authorize and request the Georgia Composite Medical Board to obtain any criminal history information concerning me from any authorized law enforcement agency, including but not limited to the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC).

I hereby release to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to evaluate my qualifications to practice medicine, including, but not limited to my moral character, professional reputation and fitness to safely practice medicine.

I hereby release, discharge, and exonerate the Georgia Composite Medical Board, its agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Composite Medical Board.

I authorize the Georgia Composite Medical Board to release information, material, documents, or the like relating to me or to this application to any other State or Territory of the United States or Province of Canada, a law enforcement agency, hospital or other appropriate agencies as determined by the Georgia Composite Medical 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 pursuant to the Official Code of Georgia Annotated, Section 43-34-46, any person who shall give false or forged evidence of any kind to the Board in connection with an application for a license to practice medicine shall be guilty of a felony and upon conviction thereof, shall be punished by a fine of not less than $500.00 nor more than $1,000.00, or by imprisonment from two to five years, or both.

I understand that I must limit my activities under the training permit to such acts as may be prescribed by or incidental to the training program, that I may train only under the supervision of physicians responsible for supervision as part of the training program and may practice in facilities affiliated with the program only if such practice is part of the training program.

SIGNATURE OF APPLICANT	**DATE**	CITY	COUNTY	STATE

PRINTED NAME OF APPLICANT

_____

Being duly sworn, says that he/she is the person who executed the above application for a temporary postgraduate training permit in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant. In addition, I will immediately notify the Board in writing of any changes to the answers to questions contained in the Applicant Questionnaire if such a change in answer is warranted at anytime, prior to being granted a temporary postgraduate training permit by the Georgia Composite Medical Board.

NOTARY SEAL MUST BE IMPRINTED HERE

Sworn and subscribed to me this _____day of _____, 20_____. My Commission Expires

_____(Notary Public) _____