Georgia Composite Medical Board Use Only

Temporary #: _____ File Number: _____

Date Issued: _____ License Number: _____

Date Issued: _____

☐ **Check this box if you are applying for an Administrative License (non-clinical practice)**

Initial Physician Application

All fees are nonrefundable and subject to change.

Name and Personal Detail

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. §651 and 20 U.S.C.A. § 1001. This information may also be disclosed to the National Practitioner Data Bank or other state medical boards or regulatory agencies for license tracking purposes.

Social Security Number _____

Last Name (Surname) _____

First _____

Middle _____

Other Surnames _____

Degree ☐ MD ☐ DO Specialty _____

Gender ☐ Male ☐ Female

Birth Date (mm/dd/yy) ____/____/____

Contact Detail Summary

General Addresses

Mailing Address: Correspondence from the Board is sent to this address. Email address is utilized by the Board to contact you in case of an emergency situation. This address will not appear on the Internet *unless you **fail** to provide a practice location address.*

_____

Street Number Street Name City State Zip Apt

_____

Area Code Phone Number Email _____@_____

Practice Location/Administrative Office Location: Posted on the Internet when the license number is issued.

!!Your mailing address will appear on the Internet if you do not provide a practice/office location!!

_____

Street Number Street Name City State Zip Suite/Bldg

_____

Area Code Phone Number

Applicant Questionnaire:

"Yes" responses require a personal explanation and supporting documentation.

	YES	NO
1.During the last 7 years, have you suffered from any physical, psychiatric, or substance use disorder that could impair or require limitations on your functioning as a professional or has resulted in the inability to practice medicine for more than 30 days, or required court-ordered treatment or hospitalization? (If yes, provide treatment history documentation to include diagnosis, treatment regimen, hospitalization, and ongoing treatment/medication to the Board. **NOTE: If you are currently enrolled in GAPHP, you may check NO.**	❑	❑
2. Have you entered a plea bargain, been arrested, indicted or convicted for violating any state or federal law including DUI (excluding minor traffic violations)? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding, regardless of whether the adjudication of guilt or sentence is withheld or not entered.	❑	❑
3. Have you ever been denied the privilege of taking an examination given by any licensing Board or Agency?	❑	❑
4. Has any licensing Board or agency ever taken a **public or private** disciplinary action against you?	❑	❑
5. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	❑	❑
6. Have you ever been denied a DEA registration number?	❑	❑
7. Have you ever been issued a restricted DEA registration?	❑	❑
8. Are you currently registered with the DEA? If yes, provide DEA number_____ and State of Issue _____	❑	❑
9. Have you ever been named as a party in a malpractice suit, arbitration hearing, State Review panel proceeding, or a VA/Federal agency review?	❑	❑
10. Have you ever resigned from a hospital staff position or training program after a complaint or peer review action has been initiated against you?	❑	❑
11. Have you ever been denied membership in, or in any way sanctioned, by any medical or osteopathic association, society, or specialty society?	❑	❑
12. Have you ever surrendered a medical license?	❑	❑
13. Have you ever surrendered a controlled substance registration?	❑	❑
14. Have you ever surrendered a DEA registration?	❑	❑
15. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	❑	❑
16. Do you have any applications for licensure pending before any other licensing Board or agency? If yes, provide a list.	❑	❑
17. Have you ever had any restrictions as a Medicaid or Medicare provider?	❑	❑
18. Are you in default on a state or federally funded and/or guaranteed school loan?	❑	❑
19. Are you in default on child support payments?	❑	❑
20. Do you intend to practice medicine in Georgia? Please provide your plans below:	❑	❑

_____

Program Questions

1. What examinations have you taken? ☐ USMLE ☐ NBME ☐ COMLEX ☐ ___________State Board Structured Examination ☐ LMCC ☐ FLEX ☐ NBOME

2. How long have you lived in the US? ______years _____months

3. Have you served in the U.S. Armed Forces? If yes provide a copy of Military Discharge Paperwork ☐ Yes ☐ No

4. Are you Board certified in your specialty? ☐ Yes ☐ No
If yes, provide specialty ________________________________

5. Will you be using FCVS? ☐ Yes ☐ No

6. Are you a US Citizen? ☐ Yes ☐ No

If you are not a U.S. citizen, you must submit documentation that will determine if you have a qualified alien status. **Only those applicants who can provide proof will be granted a license.** The Board participates in the **DHS-USCIS SAVE** (Systematic Alien Verification for Entitlements or "SAVE") program for the purpose of verifying citizenship and immigration status information of non-citizens. In order to confirm your status with the SAVE program, you need to provide the board with **legible** copies of **one** of the documents on the enclosed list.

License History

Provide history for each permanent, temporary, training, provisional, or limited licensed obtained in any state in the US, Canadian Territory or Province, or US Federal Jurisdiction.

State __________ **Country** ______________________ **Status** ____________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State __________ **Country** ______________________ **Status** ____________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State __________ **Country** ______________________ **Status** ____________________

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Issued From: (mm/dd/yy) To: (mm/dd/yy)

State __________ **Country** ______________________ **Status** ____________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

License History (continued)

State __________ **Country** ______________________ **Status** ____________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State __________ **Country** ______________________ **Status** ____________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State __________ **Country** ______________________ **Status** ____________________

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State __________ **Country** ______________________ **Status** ____________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

REVISED:7-2013

Medical/Osteopathic Education

Pre-medical Education

Beginning month and ending year for each year of attendance is required.

College _____

1st. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
2nd. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
3rd. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
4th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
5th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
6th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
7th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
8th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
9th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)

Medical Education

Beginning month and ending year for each year of attendance is required.

Medical School _____

1st. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
2nd. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
3rd. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
4th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
5th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
6th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
7th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
8th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)
9th. Year	From:	_____	(mm/yy)	TO:	_____	(mm/yy)

Post Graduate Training

Specialty _____

Hospital _____

Address _____

City/State/Zip _____

Specialty _____

Hospital _____

Address _____

City/State/Zip _____

Print page if you have more to list.

Hospital Privileges

Have you ever held any hospital privileges? ☐ Yes ☐ No

Hospital _____

Address _____

City/State/Zip _____

Hospital _____

Address _____

City/State/Zip _____

Hospital _____

Address _____

City/State/Zip _____

Hospital _____

Address _____

City/State/Zip _____

Hospital _____

Address _____

City/State/Zip _____

Hospital _____

Address _____

City/State/Zip _____

Print page if you have more hospitals to list