GEORGIA COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
MANDATORY PHYSICIAN PROFILE QUESTIONNAIRE
2 Peachtree Street, N.W., 36th Floor
Atlanta, GA 30303
(404) 656-3913
You may also complete this form at our website.
www.gaphysicianprofile.org

I. PHYSICIAN DATA – See Instructions

A. NAME:

_____
(LAST) (FIRST) (MIDDLE) (SUFFIX)

B. GEORGIA LICENSE NUMBER: _____ ☐ **MD** ☐ **DO**

RECIPROCITY:
If your original license was issued in another state, please indicate the state and date of your first license.
State_____ **Date**_____
MM/DD/YYYY

C. MAILING ADDRESS:

_____ _____ _____ _____ _____
(STREET AND NUMBER) (CITY) (STATE) (ZIP CODE) (COUNTRY)

D. PRIMARY PRACTICE ADDRESS: Check here if same as mailing address and go to Section E. ☐ (This will be published as part of the profile and the web site).

_____ _____ _____ _____ _____
(STREET AND NUMBER) (CITY) (STATE) (ZIP CODE) (COUNTRY)

E. PRACTICE LOCATION HISTORY

LOCATION OF PREVIOUS PRACTICE			FROM	TO
CITY	**STATE**	**COUNTRY**	**MM/DD/YYYY**	**MM/DD/YYYY**
1.				
2.				
3.				
4.				
5.				

F. ARE YOU CURRENTLY ACCEPTING MEDICAID PATIENTS? ☐ **Yes** ☐ **No**

Physician Name: _____ License Number: _____

II. MEDICAL EDUCATION AND TRAINING – See Instructions

A. Please indicate medical school from which you graduated:

MEDICAL SCHOOL	FROM MM/DD/YYYY	TO MM/DD/YYYY	GRADUATION DATE MM/DD/YYYY

Beginning with the most recent, provide name of any other medical school/institution attended and dates of attendance.

MEDICAL SCHOOL	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.		
2.		
3.		

B. Beginning with the most recent, provide the name, location and dates of **all completed** professional/postgraduate training. Do not include coursework taken to meet the continuing education requirements for license renewal.

GRADUATE MEDICAL EDUCATION (e.g. Pediatrics, Family Practice, etc.)	LOCATION OF TRAINING			FROM MM/DD/YYYY	TO MM/DD/YYYY
	City	State	Country		
1.					
2.					
3.					
4.					
5.					

III. SPECIALITY BOARD CERTIFICATIONS – See Instructions

Please list specialty board certifications if applicable.

CERTIFYING BOARD	SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	

Physician Name: _____ License Number: _____

IV. CURRENT HOSPITAL STAFF PRIVILEGES - See Instructions

Do you currently hold staff privileges in a hospital? If "Yes," list each.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

V. FINAL DISCIPLINARY ACTIONS - See Instructions

A. On or after April 11, 2001 have you had any final public disciplinary action or second or subsequent final private reprimand taken against you by a licensing board regulating your medical, or any other license in this state, or any other state? If "YES" list name(s) and address(es) of agency(s) of the final disciplinary action(s) and stated reason(s) for taking this action.

☐ **Yes** ☐ **No**

AGENCY NAME/ADDRESS

_____

_____

_____

City State Zip

Date of Discipline _____
MM/DD/YYYY

TYPE OF VIOLATION

- ☐ Quality of Care
- ☐ Unprofessional Conduct
- ☐ Impairment (i.e. found unable to practice medicine with reasonable skill and safety by reason of illness, drugs, alcohol or a result of any mental or physical condition.
- ☐ Aided and/or assisted any unlicensed person to practice medicine.
- ☐ Other _____

DESCRIPTION OF ACTION

- ☐ License Refusal
- ☐ Revocation
- ☐ Suspension
- ☐ Fine(s)
- ☐ Reprimand
- ☐ Voluntary Surrender
- ☐ Probation, how long? _____
- ☐ Submission to care, counseling or treatment by physician or other professional person as directed by the board.
- ☐ Limitation or restriction of license. (please describe)

_____

_____

- ☐ Other _____

Physician Name: _____ License Number: _____

V. FINAL DISCIPLINARY ACTION - Continued

AGENCY NAME/ADDRESS

_____

_____

_____
City State Zip

Date of Discipline _____
MM/DD/YYYY

TYPE OF VIOLATION

- ☐ Quality of Care
- ☐ Unprofessional Conduct
- ☐ Impairment (i.e. found unable to practice medicine with reasonable skill and safety by reason of illness, drugs, alcohol or a result of any mental or physical condition
- ☐ Aided and/or assisted any unlicensed person to practice medicine.
- ☐ Other _____

DESCRIPTION OF ACTION

- ☐ License Refusal
- ☐ Revocation
- ☐ Suspension
- ☐ Fine(s)
- ☐ Reprimand
- ☐ Voluntary Surrender
- ☐ Probation, how long? _____
- ☐ Submission to care, counseling or treatment by physician or other professional person as directed by the board.
- ☐ Limitation or restriction of license. (please describe)

_____

_____

- ☐ Other _____

B. On or after April 11, 2001, have you had your hospital privileges revoked involuntarily or by agreement, or restricted for reason(s) related to competence or character? ☐ **Yes** ☐ **No**

HOSPITAL NAME/ADDRESS

_____

_____

_____
City State Zip

Date of Discipline _____
MM/DD/YYYY

TYPE OF VIOLATION

- ☐ Quality of Care
- ☐ Unprofessional Conduct
- ☐ Impairment (i.e. drugs, alcohol or mental or physical condition
- ☐ Aided and/or assisted any unlicensed person to practice medicine.
- ☐ Other _____

DESCRIPTION OF ACTION

- ☐ Suspension
- ☐ Revocation of privileges
- ☐ Staff privileges denied, revoked or restricted
- ☐ Resignation in lieu of disciplinary action
- ☐ Voluntary Surrender
- ☐ Probation, how long? _____
- ☐ Limitation or restriction of license. (please describe)

_____

_____

- ☐ Other _____

Physician Name: _____ License Number: _____

VI. CRIMINAL OFFENSES - See Instructions

Have you been convicted of a felony, irrespective of the pendancy or availability of an appeal, or pled guilty or nolo contendere to a **felony** in any jurisdiction? If "YES," briefly describe the offense(s):

☐ **Yes** ☐ **No**

DESCRIPTION OF OFFENSE	DATE MM/DD/YYYY	JURISDICTION
1.		
2.		
3.		
4.		
5.		
6.		

VII MEDICAL MALPRACTICE JUDGMENT ARBITRATION AWARDS – See Instructions

Have you had a medical malpractice court judgment(s) and or arbitration award(s) entered on or after April 11, 2001, in which payment in excess of $100,000 was awarded against you to the complaining party? If yes, complete the following.

☐ **Yes** ☐ **No** if no skip to Section VIII

ANY JUDGMENTS OR ARBITRATION AWARDS GREATER THAN $100,000

DATE MM/DD/YYYY	AMOUNT

Physician Name: _____ License Number: _____

VIII. MEDICAL MALPRACTICE SETTLEMENTS – See Instructions

Read all malpractice questions before answering and only answer most appropriate question.

A. Have you had **four or more** medical malpractice settlements made by or on behalf of or attributable to you to the complaining party on or after April 11, 2001, regardless of the amount of the payment made by or on behalf of and attributable to you in any such settlement? If "YES, " list monetary amount and date of each settlement, and then proceed to Section IX.

☐ Yes

DATE MM/DD/YYYY	AMOUNT

B. Have you had any **three medical malpractice settlements and at least one payment in excess of $100,000** on or after April 11, 2001 and was made by or on behalf of and attributable to you in any one or more of such settlements? If yes, list monetary amount and date of each settlement and then proceed to Section IX.

☐ Yes

DATE MM/DD/YYYY	AMOUNT

C. Have you had any **medical malpractice settlements, in which payment in excess of $300,000** was made by or on behalf of and attributable to you to the complaining party on or after April 11, 2001? If yes, list monetary amount and date of each settlement against you greater than $300,000 and then proceed to Section IX.

☐ Yes

DATE MM/DD/YYYY	AMOUNT

D. ☐ No - None of the above. Proceed to Section IX.

Physician Name: _____ License Number: _____

IX. OPTIONAL INFORMATION LIMITED TO MOST RECENT TEN YEARS - See Instructions

A. LIST UP TO FOUR PUBLICATIONS: (articles you have authored publications and journals):

TITLE	PUBLICATION	DATE MM/ YYYY
1.		
2.		
3.		
4.		

B. LIST UP TO FIVE PROFESSIONAL ORGANIZATIONS, COMMUNITY SERVICE ORGANIZATION MEMBERSHIPS OR ACTIVITIES

1.
2.
3.
4.
5.

C. LIST UP TO SIX AWARDS

AWARD/HONOR	ORGANIZATION
1.	
2.	
3.	
4.	
5.	

Physician Name: _____ License Number: _____

D. LANGUAGES OTHER THAN ENGLISH: Indicate all languages other than English including sign language used by you to communicate with patients and/ or translation services available for patients at your primary practice location.

1.	4.
2.	5.
3.	6.

E. WITHIN THE PAST TEN YEARS LIST ALL APPOINTMENTS TO MEDICAL SCHOOL FACULTIES. (Not hospital affiliations or privileges)

1.	4.
2.	5.
3.	6.

X. PHYSICIAN COMMENTS – See Instructions

You may provide a statement to be included with your profile not exceeding 100 words.

Physician Name: _____ License Number: _____

☐ I swear or affirm that the statements that I have entered are true and correct and that I understand that my profile may be selected for verification of the information provided. I recognize that providing false information or incomplete information may result in disciplinary actions against my license pursuant to O.C.G.A. §§ 43-1-19 and 43-34-37 and may result in criminal penalties.

_____ _____

Signature of Physician Date