

FORM B - CONTINUED
REFERENCE FORM – INITIAL PHYSICIAN LICENSURE

**PLEASE CONFIRM THAT THE FOLLOWING RESPONSES ARE CORRECT BEFORE SUBMITTING THIS FORM.
INAPPROPRIATE ANSWERS WILL RESULT IN A DELAY IN PROCESSING YOUR APPLICATION.**

If you answer "YES" to questions 1-7, please provide an explanation.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you ever received reports of poor medical practice by this physician, or have you discussed concerns you had about this physician's practice with medical staff officers at a hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever received reports of poor relationships between this physician and other members of hospital staff? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does this physician have, or has this physician had in the past, any mental or physical illnesses or personal problems that interfere with his/her medical practice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has this physician ever abused alcohol or drugs or shown signs of chemical dependency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answer "NO" to questions 8-11, please provide an explanation.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 8. Does this physician accept medical staff and hospital policies and function willingly according to these policies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does this physician enjoy professional respect among his/her colleagues and in the community where applicant practices? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you sorry to see this physician leave your community? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you recommend this physician for unrestricted medical licensure in Georgia? | <input type="checkbox"/> | <input type="checkbox"/> |

If you have any comments regarding this applicant, please put your response in writing and attach it to this form. Please sign, provide your title, name of hospital if applicable and the date.

SIGNATURE

TITLE

HOSPITAL (IF APPLICABLE)

DATE