Georgia Composite Medical Board Use Only

Temporary #: _____ File Number: _____

Date Issued: _____ License Number: _____

Date Issued: _____

Physician Assistant REINSTATEMENT 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 _____

Gender □ Male □ Female

Georgia License Number:_____

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: 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 location!!

Street Number Street Name City State Zip Suite/Bldg

Area Code Phone Number

PHYSICIAN ASSISTANT
APPLICANT QUESTIONNAIRE

	IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO ATTACH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON, AND DISPOSITON OF THE MATTER (INCLUDE COPIES OF COURT ORDERS OR MALPRACTICE SUITS IF APPLICABLE) AND MAIL THIS FORM WITH APPROPRIATE DOCUMENTS DIRECTLY TO THE GEORGIA MEDICAL BOARD.	**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 by any State licensing board or been denied a certificate/licensure, or refused renewal of a certificate or license by any licensing board or agency?	___	___
4.	Has any licensing Board or agency ever taken a **public or private** disciplinary action against you?	___	___
5.	Are you currently registered with the DEA? If yes, provide the number and state of issue below: DEA Number _____ State of issue_____	___	___
6.	Have you ever been named as a party in a malpractice suit, arbitration hearing, military review, State Review panel proceeding, or VA/federal agency review?	___	___
7.	Have you ever had your hospital privileges limited, denied or revoked?	___	___
8.	Have you ever relinquished your hospital privileges?	___	___
9.	Have you ever voluntarily surrendered a DEA registration?	___	___
10.	Have you ever voluntarily surrendered your PA certificate/license?	___	___
11.	Do you have any applications for licensure pending before any other licensing Board or agency?	___	___
12.	Have you ever had any restrictions as a Medicaid or Medicare provider?	___	___
13.	Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	___	___

	PHYSICIAN ASSISTANT APPLICANT QUESTIONNAIRE (con't)	YES	NO
14.	Have you ever defaulted on a state or federally funded and/or guaranteed school loan?	___	___
15.	Have you ever defaulted on child support payments?	___	___
16.	Have you served in the armed forces? If yes, please provide copy of DD214.	___	___
17.	Are you a Georgia state employee? If yes, enter the Facility Name:_____	___	___
18.	Are you a Georgia county employee? If yes, enter the Facility Name:_____	___	___
19.	Have you ever taken the NCCPA Exam? If yes, enter date of Last Exam: _____ (MM/DD/YYYY)	___	___
20.	Are you currently certified by the NCCPA? If yes, enter Certificate #:_____	___	___
21.	Have you ever taken the NCCAA exam? If yes, enter date of Last Exam: _____ (MM/DD/YYYY)	___	___
22.	Are you currently certified by the NCCAA? If yes, enter Certificate #::_____	___	___
23.	Are you a U.S. Citizen? (If no, please refer to the applicant checklist listed on our website for acceptable documentation) 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 listed on our website.	___	___
24.	Have you been practicing **prior** to reinstating your application?	___	___

License History

List all states in <u>reverse chronological order</u> that you are/have been licensed to practice as a PA by virtue of a certification issued by another duly constituted licensing Board in the United States as follows:

State	Date Licensed From (mm/dd/yyyy)	Date Licensed To (mm/dd/yyyy)	License Number	Licensure Status (Active/Inactive)

Utilization of Physician Assistant

Degree (MD/DO): _____

License Number: _____

First Name: _____

Middle Name: _____

Last Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Business Phone: _____

Type of Primary Practice Setting: _____

Telemedicine Practice: YES_____ No_____

If you checked "yes":

Please provide the physical practice address in which the PA will be using to provide Telemedicine services.

_____

_____

***If specialty is Pain Management, please refer to pain management rules and regulations for additional requirements.