



Georgia Composite Medical Board Use Only

File Number: _____
License Number: _____
Date Issued: _____

Senior Laser Practitioner
Application for Licensure

All fees are nonrefundable and subject to change.

NO APPLICATION WILL BE PROCESSED WITHOUT THE APPLICATION FEE

- 1. The type of license or certificate of registration I currently hold is:
2. The type of license or certificate of registration I have previously held is:
3. Do you have a current cosmetic laser practitioner license or certificate in another state? YES NO

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

Contact Detail Summary

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 Email @

Applicant Questionnaire

Name: _____

Social Security #: _____

Instructions: Yes” responses require a personal explanation and certified documentation.

	YES	NO
1. Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (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 # _____ 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 surrendered a professional license?		
12. Have you ever surrendered a controlled substance registration?		
13. Have you ever surrendered a DEA registration?		
14. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?		
15. Do you have any applications for licensure pending before any other licensing Board or agency? If yes, provide a list.		
16. Have you ever had any restrictions as a Medicaid or Medicare provider?		
17. Are you in default on a state or federally funded and/or guaranteed school loan?		
18. Are you in default on child support payments?		
19. Are you a US Citizen? Complete Form A		
20. Have you submitted a CV with your application?		
21. Are you currently or have you been licensed or nationally board certified for at least three years?		
22. Do you have proof of at least three years of clinical or technological medical experience or both?		
23. Are you at least 21 years of age? -		
24. Are you aware that you can only practice as a senior laser practitioner pursuant to a protocol? Complete Form D.		

License History

Name: _____

Social Security #: _____

INSTRUCTIONS: If you are now or have ever been licensed to practice in any state, original verification of license history certification is required for each permanent, temporary, training, provisional, or limited license obtained in any state in the US or Canadian territory, Canadian province, or US Federal jurisdiction. If licensed by examination, provide the state. If licensed by reciprocity, provide the state. Provide the current status of the license: active, inactive, revoked, suspended, probation, limited, etc. You may make copies of this page if more space is needed. Please complete FORM C and forward to the issuing State to request verification be sent “directly” to the Georgia Composite Medical Board.

State/Country	Date Licensed From (mm/dd/yyyy)	Date Licensed To (mm/dd/yyyy)	License#/ Licensed By	Type of License/ Licensure Status

Laser Courses

Name: _____

Social Security #: _____

- List at least **TWO laser certificates** you have received from attending laser/intense pulsed light (IPL) courses.
- **Attach copies of your certificates and send with your application.**

Organization or Individual who Taught Course/ Address, City, State, Zip	Title of Course	Date Completed (mm/dd/yyyy)

Laser Devices

Name: _____

Social Security #: _____

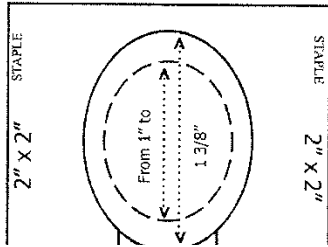
Instructions: List the types of laser devices you have used.

MEDIUM (Argon, CO ₂ , ND:YAG, etc.)	CLASS (IIB OR IV)	TYPE (CW or Pulsed)	WAVE LENGTHS (NM)	MAXIMUM OUTPUT (Watts or Joules)	Use (Medical, Research, Other)

CLINICAL AND/OR TECHNOLOGICAL MEDICAL EXPERIENCE

APPLICANT: Please list 3 years of clinical or technological medical experience, or both. Copy this page if additional space is needed.

A. NAME OF BUSINESS OR INSTITUTION:	JOB TITLE	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYMENT/ATTENDANCE: FROM: ___/___/___ M DAY YEAR TO: ___/___/___ M DAY YEAR	TYPE OF EXPERIENCE: ___ Clinical (DIRECT PATIENT CARE) ___ Technological (MEDICAL) TYPE OF EMPLOYMENT: ___ FULL-TIME ___ PART-TIME	
B. NAME OF BUSINESS OR INSTITUTION:	JOB TITLE	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYMENT/ATTENDANCE: FROM: ___/___/___ MM DAY YEAR TO: ___/___/___ MM DAY YEAR	TYPE OF EXPERIENCE: ___ Clinical (DIRECT PATIENT CARE) ___ Technological (MEDICAL) TYPE OF EMPLOYMENT: ___ FULL-TIME ___ PART-TIME	
C. NAME OF BUSINESS OR INSTITUTION:	JOB TITLE	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYMENT/ATTENDANCE: FROM: ___/___/___ MM DAY YEAR TO: ___/___/___ MM DAY YEAR	TYPE OF EXPERIENCE: ___ Clinical (DIRECT PATIENT CARE) ___ Technological (MEDICAL) TYPE OF EMPLOYMENT: ___ FULL-TIME ___ PART-TIME	



Attach Passport Photo Here

AFFIDAVIT OF APPLICANT

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 will be used to determine your qualifications for licensure per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other licensing authorities or other governmental or law enforcement agencies.

I acknowledge and state that I have read the Application 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.

I further state that by filing this application for license to practice in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to practice. 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 licensure 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, 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.

This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that pursuant to the Official Code of Georgia Annotated, Sections 43-34-246, and 43-34-8, 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 may be guilty of a felony.

Printed Name of Applicant: _____ Date: _____

Signature of Applicant: _____

Being duly sworn, says that he/she is the person who executed the application for a license to practice as a cosmetic lasers practitioner in the State of Georgia; that all the statements herein contained are true in every respect; and that the attached photo is a true photo of the applicant.

Affix the Notary
Seal/Stamp
In this space.

Sworn and subscribed to me this ____ day of _____ in the year _____.

Signature of Public Notary: _____

My Commission Expires: _____

FORM A
O.C.G.A. § 50-36-1(e)(2)
Affidavit for Professional License

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, from the Georgia Composite Medical Board, the undersigned applicant verifies one of the following with respect to my application for a public benefit:

- 1) _____ I am a United States citizen.

- 2) _____ I am a legal permanent resident of the United States.

- 3) _____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency. My alien number issued by the Department of Homeland Security or other federal immigration agency is:_____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

REQUIRED: The secure and verifiable document provided with this affidavit can best be classified as:

(List the type of document being verified by Notary – ex. Driver’s License, Passport, etc.)

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____(state).

Signature of Applicant

Printed Name of Applicant - (Print legibly)

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
__ DAY OF _____, 20__

NOTARY PUBLIC
My Commission Expires:
Senior Laser Practitioner
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Secure and Verifiable Documents Under O.C.G.A. § 50-36-2
Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 (“IIREA”) provides that “[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law’s website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General.” O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. §50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- *A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- *A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- *A driver’s license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- *An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- *A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: <http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/ind ex.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- *A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- *An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- *A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- *A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- *A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- *A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- *A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- *A driver’s license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- *A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- *A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- *In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

**FORM C
LICENSE VERIFICATION**

To be completed by the applicant. Original verification history of all licenses or certificates you have held or currently hold is required – even if you have not worked in that state for 20 years or you got a license and never practiced in that state. List the State/Country, dates of licensure, licensed by examination, reciprocity, state board examination. This form should be sent to each state in which you are now or ever have been licensed to practice. **This form may be photocopied.**

TO: _____ **Board**

FULL NAME	STREET ADDRESS	APT. NO.
SIGNATURE	CITY	STATE
		ZIP

The individual listed above has applied for licensure in Georgia. Before further consideration is given to this application, we need the information requested on this form. By signing this form, I give my consent to the release of any information, favorable or otherwise, for its review in considering me for licensure. Please mail the completed form as soon as possible to the Board at the address listed below.

**Section II: This Section to be completed by an official of the above referenced Licensing Board.
Do not return this form to the applicant, but mail it directly to:**

**Georgia Composite Medical Board
ATTN: COSMETIC LASER PRACTITIONER
2 Peachtree Street, NW - 36th Floor
Atlanta, Georgia 30303**

Title of License: _____ License number: _____

Original issue date: _____ Expiration date: _____

License status: Active Inactive Temporary Other

Licensure Method: Grandfathering Endorsement Examination

1. Has any disciplinary action ever been taken again this license? YES NO

If YES, provide the board with any documentation regarding the disciplinary action.

2. Do you have derogatory information concerning this applicant? YES NO

Print Name	Date
Signature	Office Number
Title	Fax Number
State Board	

BOARD SEAL MUST BE IMPRINTED HERE

FORM D
CONSULTING PHYSICIAN PROTOCOL AGREEMENT

THIS IS TO CERTIFY THAT THE UNDERSIGNED HAS READ AND ARE FAMILIAR WITH THE MEDICAL PRACTICE ACT RULES AND REGULATIONS PERTAINING THERETO. THIS AGREEMENT ALSO ATTESTS TO FOLLOW ALL SAFETY PROCEDURES AND RULES, AS STATED IN THE OFFICE SAFETY PROTOCOL.

SENIOR LASER PRACTITIONER INFORMATION

Senior Laser Practitioner Name (PRINT)

Senior Laser Practitioner Signature

DATE

SUPERVISING PHYSICIAN INFORMATION

The protocol agreement must also include contact information for the consulting physician in the event of problems that may arise.

Supervising Physician Name (PRINT)

LICENSE #

Supervising Physician Signature

DATE

Supervising Physician Address

City

State

Zip Code