

**GCMB Profession Database  
Order Form**

**INSTRUCTIONS:**

- ✓ Check the Profession(s) you wish to order
- ✓ Include contact information for Requestor and Receiver of data if different
- ✓ Attach check or money order payable to **GCMB** or **Georgia Composite Medical Board** and mail to the:

**Georgia Composite Medical Board  
Attn: Licensure Database  
2 MLK Jr. Drive SE  
East Tower, 11<sup>th</sup> Floor  
Atlanta, Georgia 30334**

Orders are either emailed or mailed First Class, 48 hours following receipt of this form.  
(You may provide your own UPS/FedEx packaging for RUSH delivery.)

If you need to verify receipt of the order or have any questions, contact (404) 656-3913 or [medbd@dch.ga.gov](mailto:medbd@dch.ga.gov)

**CHECK CATEGORY:**

- |  |  |
|--|--|
| <input type="checkbox"/> Acupuncturist (\$200)                 | <input type="checkbox"/> Clinical Perfusionist (\$200)   |
| <input type="checkbox"/> Cosmetic Laser Practitioner (\$200)   | <input type="checkbox"/> Genetic Counselors (\$200)      |
| <input type="checkbox"/> Pain Management Clinic (\$200)        | <input type="checkbox"/> Physicians (MD & DO) (\$500)    |
| <input type="checkbox"/> Physician Assistant (\$200)           | <input type="checkbox"/> Residency Training (\$200)      |
| <input type="checkbox"/> Respiratory Care Professional (\$200) | <input type="checkbox"/> Orthotist & Prosthetist (\$200) |
| <input type="checkbox"/> All professions (\$1,100)             |  |

\*\*Type or print neatly\*\*

Requestor's Name & Company

Recipient's Name (If different from Requestor's)

Telephone Number

Email Address

Physical Delivery Address

**OR**

Enter FTP address, if applicable

City

State

Zip Code

**OR**

Enter FTP address, if applicable

**GCMB Use Only**

Date Received

Date Filled

Initials \_\_\_\_\_