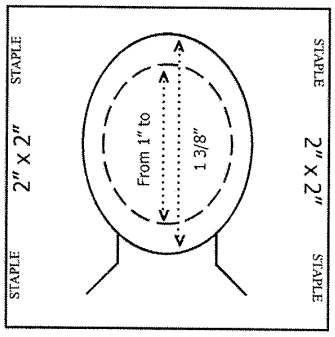
NAME: _____ **SOCIAL SECURITY #:** _____

(PLEASE PRINT LEGIBLY OR TYPE)

DATE OF BIRTH: _____



Attach Passport Photo Here

FORM A: AFFIDAVIT OF APPLICANT
(MUST BE COMPLETED BY EACH OWNER)

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. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards 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, copies of which are sent to applicants.

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

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.

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, Section 43-34-46, any person who shall give false or forged evidence of any kind to the Board in connection with this application shall be guilty of a felony.

Name of Applicant (Print or type): _____ Date Signed: _____

Signature of Applicant: _____

Being duly sworn, says that he/she is the person who executed the application for a pain management clinic license 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: _____