FORM C
PAIN MANAGEMENT CLINIC
HOSPITAL ANNUAL NOTIFICATION FORM

If your hospital operates an outpatient clinic at its main facility or at any satellite facility with greater than 50 percent of such clinic's annual patient population being treated for chronic pain for non-terminal conditions by the use of Schedule II or III controlled substances, please complete the information below.

_____

Hospital Name (Type or print legibly)

_____

Pain Management Clinic Name (Type or print legibly)

Pain Management Clinic Address (type or print legibly):

_____

(Street Address) (Suite #)

_____

(City) (State) (Zip Code) (County)

Telephone Number: _____ Fax Number: _____

Email Address: _____

Hospital Address

_____

(Street) (Suite #)

_____

(City) State (Zip Code) (County)

Telephone Number: _____ Fax Number: _____

Email Address: _____

Hospital Mailing Address

_____

(Street) (Suite #)

_____

(City) State (Zip Code) (County)

Telephone Number: _____ Fax Number: _____

Email Address: _____

Physician or Clinic Director Name_____ License Number _____

Signature _____Date _____

Please mail this form to: GCMB
2 Peachtree Street, N.W. – 36th Floor
Atlanta, Georgia 30303