FORM B11
RESPIRATORY CARE
REFERENCE FORM

To be completed by Prospective Employer:

In order for the Georgia Composite Medical Board to adequately evaluate the applicant named below for certification to practice as a Respiratory Care Practitioner in the State of Georgia, please complete all pertinent sections in detail. This reference form must be completed and signed by a **licensed physician** with whom the **applicant intends to practice.** This form must be mailed **directly from the physician to** the Georgia Composite Medical Board **at the following address:**

Georgia Composite Medical Board
Respiratory Care Professional Unit
2 Peachtree Street, N.W. – 36th Floor
Atlanta, GA 30303

I hereby certify that _____ will be employed under my

supervision as a Health Care Professional in Respiratory Care effective ____/____/____

Applicant will work: ☐ full time ☐ part time, approximately ____ hours per week.

Additional Comments:_____

_____

_____

Physician Name: _____

please type or print

Physician Signature: _____ **Date:** _____

License Number: _____ **State:** _____

Business Name: _____

Mailing Address: _____

_____

City **State** **Zip Code**

Business Telephone Number: _____