FORM A
Exceptional Circumstances Consideration Form
INSTITUTION

Please print legibly:

Institutional Physician Name _____
Last Name **First Name** **Middle**

Institutional Physician Specialty:_____

Supervisory Oversight Physician:_____ **___MD ___DO**
(Supervisory Oversight means the onsite direction of the supervisor with immediate availability.

Does your supervisory oversight physician have an unrestricted license to practice medicine in the State of Georgia? _____YES _____NO

Supervisory Oversight Physician Specialty:_____
(must be same as that of the applicant physician)

Type of Supervision Being Provided:_____

_____

Institution Name: _____

Institution Address:_____

_____
City **State** **Zip Code** **Phone Number**

1. Is this institution in a medically underserved area?
   _____YES _____NO

   If yes, please submit evidence. Such evidence should include but not be limited to:
   (a) Deficient physician staff to service the health care needs of the population.
   (b) Institution can demonstrate failed attempts to recruit licensed physicians to satisfy the deficiency.

2. Is this institution licensed by the Department of Community Health?
   _____YES _____NO

3. Is this physician applicant a graduate of an international medical school and does not qualify for licensure under other provisions of Chapter 43-34-26?
   _____YES _____NO

   If yes, please submit evidence. Such evidence should include but not be limited to:
   (a) Applicant is from a war torn country.
   (b) Applicant has applied for political asylum in the United States.

NOTE: The Board may require the physician applicant and a representative of the institution to appear for a personal interview before the Board or the committee.

Hospital Administrator Signature	**Date Signed**
Applicant Physician Signature	**Date Signed**

Return the completed form to:
Georgia Composite Medical Board
Attention: Institutional Physician Licensure
2 Peachtree Street, N.W., - 36th Floor
Atlanta, GA 30301