



Georgia Composite Medical Board Use Only

Temporary #: _____ File Number: _____

Date Issued: _____ License Number: _____

Date Issued: _____

Physician Assistant REINSTATEMENT Application

All fees are nonrefundable and subject to change.

Name and Personal Detail

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. § 651 and 20 U.S.C.A. § 1001. This information may also be disclosed to the National Practitioner Data Bank or other state medical boards or regulatory agencies for license tracking purposes.

Social Security Number _____

Last Name (Surname) _____

First _____

Middle _____

Other Surnames _____

Gender Male Female

Birth Date (mm/dd/yy) _____ / _____ / _____

Contact Detail Summary

General Addresses

Mailing Address: Correspondence from the Board is sent to this address. Email address is utilized by the Board to contact you in case of an emergency situation. This address will not appear on the Internet *unless you fail to provide a practice location address.*

Street Number Street Name City State Zip Apt

Area Code Phone Number Email @

Practice Location: Posted on the Internet when the license number is issued.

!!Your mailing address will appear on the Internet if you do not provide a practice location!!

Street Number Street Name City State Zip Suite/Bldg

Area Code Phone Number



PHYSICIAN ASSISTANT APPLICANT QUESTIONNAIRE

| | IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO ATTACH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON, AND DISPOSITION OF THE MATTER (INCLUDE COPIES OF COURT ORDERS OR MALPRACTICE SUITS IF APPLICABLE) AND MAIL THIS FORM WITH APPROPRIATE DOCUMENTS DIRECTLY TO THE GEORGIA MEDICAL BOARD. | YES | NO |
|-----|---|-----|----|
| 1. | During the last seven years, were you treated for alcohol, mental or physical disorder, chemical drug dependency, neurologic, or psychiatric illness that required outpatient evaluation or inpatient hospitalization? (If yes, provide treatment history documentation to include diagnosis, treatment regimen, hospitalization, and ongoing treatment/medication to the Board. | — | — |
| 2. | Have you entered a plea bargain, been arrested, indicted or convicted for violating any state or federal law including DUI (excluding minor traffic violations)? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding, regardless of whether the adjudication of guilt or sentence is withheld or not entered. | — | — |
| 3. | Have you ever been denied the privilege of taking an examination by any State licensing board or been denied a certificate/licensure, or refused renewal of a certificate or license by any licensing board or agency? | — | — |
| 4. | Has any licensing Board or agency ever taken a public or private disciplinary action against you? | — | — |
| 5. | Are you currently registered with the DEA? If yes, provide the number and state of issue below: DEA Number _____ State of issue _____ | — | — |
| 6. | Have you ever been named as a party in a malpractice suit, arbitration hearing, military review, State Review panel proceeding, or VA/federal agency review? | — | — |
| 7. | Have you ever had your hospital privileges limited, denied or revoked? | — | — |
| 8. | Have you ever relinquished your hospital privileges? | — | — |
| 9. | Have you ever voluntarily surrendered a DEA registration? | — | — |
| 10. | Have you ever voluntarily surrendered your PA certificate/license? | — | — |
| 11. | Do you have any applications for licensure pending before any other licensing Board or agency? | — | — |
| 12. | Have you ever had any restrictions as a Medicaid or Medicare provider? | — | — |
| 13. | Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency? | — | — |



| | PHYSICIAN ASSISTANT APPLICANT QUESTIONNAIRE (con't) | YES | NO |
|-----|---|-----|----|
| 14. | Have you ever defaulted on a state or federally funded and/or guaranteed school loan? | — | — |
| 15. | Have you ever defaulted on child support payments? | — | — |
| 16. | Have you served in the armed forces? If yes, please provide copy of DD214. | — | — |
| 17. | Are you a Georgia state employee? If yes, enter the Facility Name: _____ | — | — |
| 18. | Are you a Georgia county employee? If yes, enter the Facility Name: _____ | — | — |
| 19. | Have you ever taken the NCCPA Exam? If yes, enter date of Last Exam: _____ (MM/DD/YYYY) | — | — |
| 20. | Are you currently certified by the NCCPA? If yes, enter Certificate #: _____ | — | — |
| 21. | Have you ever taken the NCCAA exam? If yes, enter date of Last Exam: _____ (MM/DD/YYYY) | — | — |
| 22. | Are you currently certified by the NCCAA? If yes, enter Certificate #: _____ | — | — |
| 23. | Are you a U.S. Citizen? (If no, please refer to the applicant checklist listed on our website for acceptable documentation) | — | — |

If you are not a U.S. citizen, you must submit documentation that will determine if you have a qualified alien status. **Only those applicants who can provide proof will be granted a license.** The Board participates in the **DHS-USCIS SAVE** (Systematic Alien Verification for Entitlements or "SAVE") program for the purpose of verifying citizenship and immigration status information of non-citizens. In order to confirm your status with the SAVE program, you need to provide the board with **legible** copies of **one** of the documents listed on our website.



License History

List all states in reverse chronological order that you are/have been licensed to practice as a PA by virtue of a certification issued by another duly constituted licensing Board in the United States as follows:

| State | Date Licensed From (mm/dd/yyyy) | Date Licensed To (mm/dd/yyyy) | License Number | Licensure Status (Active/Inactive) |
|-------|------------------------------------|----------------------------------|----------------|---------------------------------------|
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Utilization of Physician Assistant

Degree (MD/DO): _____

License Number: _____

First Name: _____

Middle Name: _____

Last Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Specialty: _____

Current Board Certifications: _____

Business Phone: _____

Type of Primary Practice Setting: _____