

APPLICATION FOR TEACHER'S LICENSE

GEORGIA COMPOSITE MEDICAL BOARD (GCMB) USE ONLY

ATTACH CHECK HERE	AP NUMBER	_____	FILE NUMBER	_____
	RECEIVED	_____	COMPLETED	_____
	Teachers Lic No	_____	Issue Date	_____
	WITHDRAWN	_____	Expiration Date	_____
	DATE WITHDRAWN	_____	DATE DENIED	_____
	DENIED	_____		

F E E S A R E
S U B J E C T T O
C H A N G E

BASIC INFORMATION

1. US Social Security Number: _____ - _____ - _____				
2. LAST NAME		FIRST NAME	MIDDLE NAME	DEGREE (MD OR DO)
MAIDEN NAME	SEX M F	DATE OF BIRTH (MM/DD/YY)	NAME OF MEDICAL SCHOOL	
<input type="checkbox"/> I am a U.S. Citizen <input type="checkbox"/> I am <u>not</u> a U.S. Citizen, but am a qualified alien under the Federal Immigration and Naturalization Act, and I am lawfully present in the United States. (IF YOU CHECKED THIS BOX, SEE CHECKLIST REQUIREMENTS FOR SUBMITTING SUPPORTING DOCUMENTATION)				
3. Mailing address – This address will be used to mail application status information.				
STREET NUMBER		STREET NAME		APARTMENT #
CITY	STATE	ZIP CODE	COUNTY	
()	()		@	
(AREA CODE) PHONE NUMBER		(AREA CODE) FAX NUMBER (OPTIONAL)		E-MAIL ADDRESS
4. Practice street address – This address will appear on the internet.				
STREET NUMBER		STREET NAME		SUITE #
CITY	STATE	ZIP CODE	COUNTY	
()	()			
(AREA CODE) PHONE NUMBER		(AREA CODE) FAX NUMBER (OPTIONAL)		

APPLICANT QUESTIONNAIRE

INSTRUCTIONS: If you answer, "YES" to questions 1-9, you are required to furnish complete details, including date, place, reason and disposition of the matter. Failure to furnish complete documentation may result in a delay in the processing of your application. I understand that my questionnaire may be selected for verification of the information provided. I recognize that providing false information or incomplete information may result in disciplinary actions against my license pursuant to O.C.G.A. §§ 43-1-19 and 43-34-08 and may result in criminal penalties, up to and including reporting to the NPDB.	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 any licensing Board or agency ever denied you a certificate or a license?	<input type="checkbox"/>	<input type="checkbox"/>
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. Have you ever been arrested for, and/or convicted of, a violation of any Federal (including military), State or Local statute?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any licensing Board or agency ever taken a public or private disciplinary action against you?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been disciplined by any licensing Board or agency?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had any restrictions as a Medicaid or Medicare provider?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you in default on a state or federally funded and/or guaranteed school loan?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you in default on child support payments?	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you include a copy of your CV or résumé with this application packet?	<input type="checkbox"/>	<input type="checkbox"/>

CERTIFICATION OF THE MEDICAL SCHOOL DEAN FOR A TEACHERS LICENSE

This is to certify that _____ is considered by this institution to be a distinguished medical scholar and he/she can make a significant contribution **by demonstrating a new technique.** This institution has conducted a thorough evaluation and validation of the applicant's medical credentials and background, and I recommend him/her without reservation **to conduct this demonstration.**

I understand that this license shall expire on_____. I further understand that it is the responsibility of this institution, including affiliated clinics, to disclose to any patients who are treated by a physician with a teacher's license that he/she is being treated by a physician who holds a teacher's license.

This applicant commences/commenced employment with the institution in a teaching capacity on _____; this appointment is expected to continue until _____.

Signature of Medical School Dean

Date

School Seal

Name of Medical School

Address

City, State Zip Code

Phone Number

Fax Number

E-mail address

AFFIDAVIT OF APPLICANT

<p>PHOTO AREA PASTE A 2 ¼" X 3" PHOTO HERE.</p> <p>PHOTO MUST BE OF YOUR HEAD AND SHOULDER AREAS ONLY</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">TOP OF PHOTO (HEAD)</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">BOTTOM OF PHOTO (SHOULDERS)</p>
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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 for licensure per Georgia Law that authorizes collection of this information. 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 for Teacher's Licensure Information and Applicant instructions that accompanied this application and I have answered all questions in compliance with these instructions. I further acknowledge that it is my responsibility to read and become familiar with the Medical Practice Act and Board's rules and regulations, including but not limited to Chapter 360-9 entitled "Teacher's License, copies of which are included with this application.

I further state that by filing this application for a teacher's license in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to participate and 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 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 State Board of Medical Examiners or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice there under.

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 43-34-42, any person who shall give false or forged evidence of any kind to the Board in connection with an application for a license to practice medicine shall be guilty of a felony and upon conviction thereof, shall be punished by a fine of not less than \$500.00 nor more than \$1,000.00, or by imprisonment from two to five years, or both.

SIGNATURE OF APPLICANT	DATE	CITY	COUNTY	STATE
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PRINTED NAME OF APPLICANT	Being duly sworn, says that he/she is the person who executed the above application for a license in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.	NOTARY SEAL MUST BE IMPRINTED HERE
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Sworn and subscribed to me this _____ day of _____, _____ _____ (Notary Public)	My Commission Expires _____
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