Georgia Composite Medical Board Use Only

Application Number #: ___________ File Number: _________________

Date Issued: ____________ License Number: _____________

Volunteer in Medicine Application

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 ______________________________

Degree ☐ MD ☐ DO Specialty ____________________

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 Email

Program Questions

How long have you lived in the US?	______years _____months	
Have you served in the U.S. Armed Forces? If yes, dates of services: From:____________________ TO:____________________________ If yes, provide a copy of Military Discharge Paperwork	☐ Yes	☐ No
Have you been discharged from the armed forces?	☐ Yes	☐ No
Are you a US Citizen?	☐ Yes	☐ No

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 on the enclosed list.

APPLICANT QUESTIONNAIRE

INSTRUCTIONS: If you answer, "YES" to questions 1-19, 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 43-34-37 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.	❑	❑
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 given by any licensing Board or agency?	❑	❑
4. Has any licensing Board or agency ever taken a **public or private** disciplinary action against you?	❑	❑
5. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	❑	❑
6. Have you ever been denied a DEA registration number?	❑	❑
7. Have you ever been issued a restricted DEA registration?	❑	❑
8. Are you currently registered with the DEA? If you are registered with the DEA, provide the number and state of issue below: DEA Number ________________________ State of issue__________________________	❑	❑
9. Have you ever been denied membership in or in any way sanctioned by any medical or osteopathic association, society, or specialty society	❑	❑
10. Have you ever resigned from a hospital staff position or training program after a complaint or peer review action has been initiated against you?	❑	❑
11. Have you ever voluntarily surrendered a medical license?	❑	❑
12. Have you ever voluntarily surrendered a controlled substance registration?	❑	❑
13. Have you ever voluntarily surrendered a DEA registration?	❑	❑
14. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	❑	❑
15. Do you have any applications for licensure pending before any other licensing Board or agency?	❑	❑
16. Have you ever had any restrictions as a Medicaid or Medicare provider?	❑	❑
17. Are you in default on a state or federally funded and/or guaranteed school loan?	❑	❑
18. Are you in default on child support payments?	❑	❑
19. Did you include a copy of your CV or résumé with this application packet?	❑	❑

License History

Provide history for each permanent, temporary, training, provisional, or limited licensed obtained in any state in the US, Canadian Territory or Province, or US Federal Jurisdiction.

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

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Issued From: (mm/dd/yy) To: (mm/dd/yy)

State ___________ **Country** _________________________ **Status** ______________________

Issued From: (mm/dd/yy) To: (mm/dd/yy)

Pre-medical Education

Beginning month and ending year for each year of attendance is required.

College ______________________________

1st. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
2nd. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
3rd. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
4th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
5th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
6th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
7th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
8th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
9th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)

Medical/Osteopathic Education
Medical Education

Beginning month and ending year for each year of attendance is required.

Medical School ______________________________

1st. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
2nd. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
3rd. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
4th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
5th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
6th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
7th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
8th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)
9th. Year	From:	________	(mm/yy)	TO:	________	(mm/yy)