| ATTACH CHECK HERE | GEORGIA MEDICAL BOARD (GMB) USE ONLY | | | |
|---|---|---|---|---|
| | AP NUMBER | ________ | FILE NUMBER | ________ |
| | RECEIVED | ________ | COMPLETED | ________ |
| | LICENSE NUMBER | ________ | DATE ISSUED | ________ |
| | WITHDRAWN | ________ | DATE WITHDRAWN | ________ |
| | DENIED | ________ | DATE DENIED | ________ |

**ALL FEES ARE NONREFUNDABLE**

**FEES ARE SUBJECT TO CHANGE**

*Social Security information is authorized to be obtained and disclosed to state and federal agencies under the Georgia Child Support Recover Act, O.C.G.A.§ 19-11-1 et seq/, O.C.G.A.§ 20-3-295(student loan defaults), the Child Support Enforcement Act 42 U.S.C.A. § 651 et. seq. and the Higher Education Act of 1965, 20 U.S.C.A.§ 1001 et. seq. This information may also be disclosed to other licensing boards or regulatory agencies for license tracking purposes. If you do not wish this information to be released to other licensing boards or other regulatory agencies for license tracking purposes, please **check here____.** You will be contacted prior to releasing this information, when necessary.

## BASIC INFORMATION – AURICULAR DETOXIFICATION LICENSURE

**1. US Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

| **2. LAST NAME** | FIRST NAME | MIDDLE NAME | MAIDEN NAME |
|---|---|---|---|
| | | | |

| SEX<br>M F | | DATE OF BIRTH (MM/DD/YY) | |
|---|---|---|---|

☐ **I am a U.S. Citizen**

☐ **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) HOME PHONE NUMBER | (AREA CODE) EMERGENCY PHONE NUMBER | | 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) DAYTIME PHONE NUMBER | (AREA CODE) BUSINESS PHONE NUMBER | | |

**5. I/am have been certified/licensed to practice as a Acupuncturist by virtue of certification issued in another duly constituted licensing Board in the United States as follows (use additional pages if necessary)**

| STATE | DATE OF CERTIFICATION/LICENSURE | CERTIFICATE OR LICENSE NUMBER | ACTIVE/INACTIVE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| APPLICANT QUESTIONNAIRE | YES | NO |
|---|---|---|
| 1. Have you ever passed the CCAOM exam and received certification for the Clean Needle Technique Certification? If you have passed, please contact the CCAOM and have them send proof of certification directly to the Composite State Board of Medical Examiners. | ❑ | ❑ |
| **INSTRUCTIONS: If you answer, "YES" to any of the following questions, you are required to furnish complete details, including an explanation, date, place, offense charged, plea, final disposition of the matter, name of court, state, count/jurisdiction (include any court orders or copies of malpractice suites if applicable).** | | |
| 2. Have you ever been arrested, convicted, sentenced, plead guilty, plead nolocontendere or been given first offender status for any offense other than a minor traffic violation? Please include any felony, any crime involving moral turpitude, any violation of state or federal laws regarding controlled substance or dangerous drugs, or any DUI offense. | ❑ | ❑ |
| 3. Have you ever had your license to practice a business or profession in Georgia or any other state or country revoked, suspended, denied, annulled, refused to be renewed, or subject to disciplinary action? | ❑ | ❑ |
| 4. To your knowledge, are you currently under investigation by any licensing board or agency as of the date of this application? | ❑ | ❑ |
| 5. Have you ever voluntarily surrendered your certification or license? | ❑ | ❑ |
| 6. Has your application for taking a licensing or certification examination ever been denied? | ❑ | ❑ |
| 7. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years? | ❑ | ❑ |

| **COLLEGE OR OTHER EDUCATION. DO NOT INCLUDE ACUPUNCTURE EDUCATION OR TRAINING:** | | | | |
|---|---|---|---|---|
| NAME OF SCHOOL | | | | |
| ADDRESS | CITY | STATE | | ZIP CODE |
| DATE OF GRADUATION | | | | |
| COURSE OF STUDY (E.G., COLLEGE PREP, ETC.) | | | | |
| **AURICULAR DETOXIFICATION EDUCATION AND TRAINING: PLEASE LIST EVERY SCHOOL YOU HAVE ATTENDED AND/OR RECEIVED TRAINING INCLUDING SCHOOLS NOT LOCATED WITHIN THE UNITED STATES. PLEASE USE ADDITIONAL SHEETS IF NECESSARY.** | | | | |
| NAME OF SCHOOL: | | | | |
| ADDRESS | CITY | STATE | | ZIP CODE |
| DATES OF ATTENDANCE | | | GRADUATION DATE: | |
| SPECIALTY (IF ANY) | | | | |
| | | | | |
| NAME OF SCHOOL: | | | | |
| ADDRESS | CITY | STATE | | ZIP CODE |
| DATES OF ATTENDANCE | | | GRADUATION DATE: | |
| SPECIALTY (IF ANY) | | | | |
| | | | | |
| NAME OF SCHOOL: | | | | |
| ADDRESS | CITY | STATE | | ZIP CODE |
| DATES OF ATTENDANCE | | | GRADUATION DATE: | |
| SPECIALITY (IF ANY) | | | | |

## Work History: Auricular Detoxification Specialist

APPLICANTS: Please complete your work history only as it relates to the practice of acupuncture. For non-acupuncture related employment, please list the employer, dates employed, and job title. DO NOT list your job duties.

**Date Form Completed:**__ __ / __ __/ __ __ __ __

| **1.** LAST NAME | FIRST NAME | MIDDLE NAME | MAIDEN NAME | DEGREE (MD OR DO) |
|---|---|---|---|---|
| | | | | |

| | SEX<br>M F | SOCIAL SECURITY NUMBER<br>__ __ __ - __ __ - __ __ __ __ | DATE OF BIRTH (MM/DD/YY)<br>__ __ / __ __/ __ __ __ __<br>CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐ |
|---|---|---|---|

| STREET NUMBER | STREET NAME | | APARTMENT # |
|---|---|---|---|
| CITY | STATE | ZIP CODE | COUNTY |

| **2. RECORD WORK HISTORY CHRONOLOGICALLY –** Complete Work History beginning with present employment and concluding with graduation. You must account for all breaks in work history, including, volunteer work and periods of unemployment. If the work was not related to the practice of acupuncture, please list only the name of the business, job title and dates worked. DO NOT list your description of job duties for non-ADT related jobs. | E-MAIL ADDRESS |
|---|---|

| **A. NAME OF BUSINESS OR INSTITUTION:** | **JOB TITLE** | |
|---|---|---|
| | | |
| ADDRESS: STREET NUMBER STREET NAME | CITY STATE | ZIP CODE |
| SUPERVISOR'S NAME: | | DESCRIPTION OF DUTIES PERFORMED |
| DATE OF EMPLOYEMENT/ATTENDANCE:<br>FROM:_____/_____/_____<br>MONTH DAY YEAR<br>TO: _____/_____/_____<br>MONTH DAY YEAR | HOURS WORKED PER WEEK:<br>__________<br>TYPE OF EMPLOYMENT:<br>____FULL-TIME ____PART-TIME | |
| TOTAL TIME WORKED<br>_____/_____<br>MONTH YEAR | **APPROXIMATE NUMBER OF PATIENTS:________**<br>**APPROXIMATE NUMBER OF PATIENT VISITS:________** | |
| **B. NAME OF BUSINESS OR INSTITUTION:** | **JOB TITLE** | |
| | | |
| ADDRESS: STREET NUMBER STREET NAME | CITY STATE | ZIP CODE |
| SUPERVISOR'S NAME: | | DESCRIPTION OF DUTIES PERFORMED |
| DATE OF EMPLOYEMENT/ATTENDANCE:<br>FROM:_____/_____/_____<br>MONTH DAY YEAR<br>TO: _____/_____/_____<br>MONTH DAY YEAR | HOURS WORKED PER WEEK:<br>__________<br>TYPE OF EMPLOYMENT:<br>____FULL-TIME ____PART-TIME | |
| TOTAL TIME WORKED<br>_____/_____<br>MONTH YEAR | **APPROXIMATE NUMBER OF PATIENTS:________**<br>**APPROXIMATE NUMBER OF PATIENT VISITS:________** | |

## Work History: Auricular Detoxification Specialist (CONTINUED)

| **C. NAME OF BUSINESS OR INSTITUTION:** | **JOB TITLE** | |
|---|---|---|
| | | |
| ADDRESS: STREET NUMBER STREET NAME | CITY STATE | ZIP CODE |
| SUPERVISOR'S NAME: | | DESCRIPTION OF DUTIES PERFORMED |
| DATE OF EMPLOYEMENT/ATTENDANCE:<br>FROM:_____/_____/_____<br>MONTH DAY YEAR<br>TO: _____/_____/_____<br>MONTH DAY YEAR | HOURS WORKED PER WEEK:<br>__________<br>TYPE OF EMPLOYMENT:<br>____FULL-TIME ____PART-TIME | |
| TOTAL TIME WORKED<br>_____/_____<br>MONTH YEAR | **APPROXIMATE NUMBER OF PATIENTS:________**<br>**APPROXIMATE NUMBER OF PATIENT VISITS:________** | |
| **D. NAME OF BUSINESS OR INSTITUTION:** | **JOB TITLE** | |
| | | |
| ADDRESS: STREET NUMBER STREET NAME | CITY STATE | ZIP CODE |
| SUPERVISOR'S NAME: | | DESCRIPTION OF DUTIES PERFORMED |
| DATE OF EMPLOYEMENT/ATTENDANCE:<br>FROM:_____/_____/_____<br>MONTH DAY YEAR<br>TO: _____/_____/_____<br>MONTH DAY YEAR | HOURS WORKED PER WEEK:<br>__________<br>TYPE OF EMPLOYMENT:<br>____FULL-TIME ____PART-TIME | |
| TOTAL TIME WORKED<br>_____/_____<br>MONTH YEAR | **APPROXIMATE NUMBER OF PATIENTS:________**<br>**APPROXIMATE NUMBER OF PATIENT VISITS:________** | |
| **E. NAME OF BUSINESS OR INSTITUTION:** | **JOB TITLE** | |
| | | |
| ADDRESS: STREET NUMBER STREET NAME | CITY STATE | ZIP CODE |
| SUPERVISOR'S NAME: | | DESCRIPTION OF DUTIES PERFORMED |
| DATE OF EMPLOYEMENT/ATTENDANCE:<br>FROM:_____/_____/_____<br>MONTH DAY YEAR<br>TO: _____/_____/_____<br>MONTH DAY YEAR | HOURS WORKED PER WEEK:<br>__________<br>TYPE OF EMPLOYMENT:<br>____FULL-TIME ____PART-TIME | |
| TOTAL TIME WORKED<br>_____/_____<br>MONTH YEAR | **APPROXIMATE NUMBER OF PATIENTS:________**<br>**APPROXIMATE NUMBER OF PATIENT VISITS:________** | |