

ATTACH CHECK HERE

**GEORGIA COMPOSITE MEDICAL BOARD (GCMB) USE ONLY**

AP NUMBER _____	FILE NUMBER _____
RECEIVED _____	COMPLETED _____
LICENSE NUMBER _____	DATE ISSUED _____
WITHDRAWN _____	DATE WITHDRAWN _____
DENIED _____	DATE DENIED _____

ALL FEES ARE NONREFUNDABLE\*

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

Please check one:

\*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 – REINSTATEMENT ACUPUNCTURIST LICENSURE**

1. US Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

2. LAST NAME FIRST NAME MIDDLE NAME MAIDEN NAME

SEX DATE OF BIRTH (MM/DD/YY)  
M F

I am a U.S. Citizen  
  
I am not 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<b>APPLICANT QUESTIONNAIRE</b>		<b>YES</b>	<b>NO</b>
1. Have you ever taken and passed the NCCAOM Examination for Acupuncturist? If you have passed, please contact the NCCAOM and have them send proof of certification directly to the Composite State Board of Medical Examiners.	<input type="checkbox"/> <input type="checkbox"/>		
2. Have you passed the NCCAOM exam and received certification for the Clean Needle Technique Certification? If you have passed, please contact CCAOM and have then send verification of your certification directly to the Composite State Board of Medical Examiners.	<input type="checkbox"/> <input type="checkbox"/>		
3. Have you been practicing since your license lapsed?  If no, enter month/year when you stopped practicing.  _____ (Month) _____ (Year)	<input type="checkbox"/> <input type="checkbox"/>		
<b>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).</b>			
4. 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.	<input type="checkbox"/> <input type="checkbox"/>		
5. 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?	<input type="checkbox"/> <input type="checkbox"/>		
6. To your knowledge, are you currently under investigation by any licensing board or agency as of the date of this application?	<input type="checkbox"/> <input type="checkbox"/>		
7. Have you ever voluntarily surrendered your certification or license?	<input type="checkbox"/> <input type="checkbox"/>		
8. Has your application for taking a licensing or certification examination ever been denied?	<input type="checkbox"/> <input type="checkbox"/>		
9. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years?	<input type="checkbox"/> <input type="checkbox"/>		

<b>COLLEGE OR OTHER EDUCATION. DO NOT INCLUDE ACUPUNCTURE EDUCATION OR TRAINING:</b>			
NAME OF SCHOOL			
ADDRESS	CITY	STATE	ZIP CODE
DATE OF GRADUATION			
COURSE OF STUDY (E.G., COLLEGE PREP, ETC.)			
<b>ACUPUNCTURE 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.</b>			
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:	
SPECIALTY (IF ANY)			

## Work History: Acupuncturist

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 M   F	SOCIAL SECURITY NUMBER _____ - _____ - _____	DATE OF BIRTH (MM/DD/YY) ___ / ___ / _____
			CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED <input type="checkbox"/>

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

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

