

GEORGIA MEDICAL BOARD (GMB) USE ONLY

REQUIRED DOCUMENTATION:
 GA MEDICAL BOARD USE ONLY
 CURRENT LICENSE IN GOOD STANDING
 RETIRED LICENSE IN GOOD STANDING
 COPY OF MEDICAL DEGREE
 STATE VERIFICATION
 NOTARIZED EMPLOYMENT FORM
 40 HOURS CME
 NPDB
 HIPDB
 RESUME
 AFFIDAVIT

APPL. NUMBER	FILE NUMBER
RECEIVED	COMPLETED
TEMP LIC NO	EXPIRATION DATE
LICENSE NO	DATE ISSUED
WITHDRAWN	DENIED

VOLUNTEER IN MEDICINE – APPLICATION FOR LICENSURE

BASIC INFORMATION

1. US Social Security Number: _____ - _____ - _____

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 also may be disclosed to the National Practitioner’s Data Bank (NPDB) or other state medical boards or regulatory agencies for license tracking purposes.

I do not wish this information to be released to the NPDB, other medical boards, or other regulatory agencies for license tracking purposes.

2. LAST NAME FIRST NAME MIDDLE NAME DEGREE (MD OR DO)

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) 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

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(AREA CODE) PHONE NUMBER (AREA CODE) FAX NUMBER (OPTIONAL)

BASIC INFORMATION (Continued)

5. How long have you lived in the US? _____ YEARS _____ MONTHS

6. Have you served in the armed forces?

Yes

No

Not applicable

DATES OF SERVICE (MM/DD/YY – MM/DD/YY)

7. Have you been discharged?

Yes

No

Not applicable

DATE OF DISCHARGE (MM/DD/YY)

TYPE OF DISCHARGE

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. Question 20 must be answered even if you do not plan to practice in Georgia. 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. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years? (Provide the Board with all treatment history documentation to include diagnosis, treatment regimen, medical regimen, hospitalization, and on-going treatment/medication.)	<input type="checkbox"/>	<input type="checkbox"/>
2. 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. Have you ever been denied the privilege of taking an examination given by any licensing Board or agency?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any licensing Board or agency ever denied you a certificate or a license?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been denied a DEA registration number?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been issued a restricted DEA registration?	<input type="checkbox"/>	<input type="checkbox"/>
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 _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been denied membership in or in any way sanctioned by any medical or osteopathic association, society, or specialty society	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever voluntarily surrendered a medical license?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever voluntarily surrendered a controlled substance registration?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever voluntarily surrendered a DEA registration?	<input type="checkbox"/>	<input type="checkbox"/>
14. To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have any applications for licensure pending before any other licensing Board or agency?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had any restrictions as a Medicaid or Medicare provider?	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you in default on a state or federally funded and/or guaranteed school loan?	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you in default on child support payments?	<input type="checkbox"/>	<input type="checkbox"/>
19. Did you include a copy of your CV or résumé with this application packet?	<input type="checkbox"/>	<input type="checkbox"/>

TRAINING

INSTRUCTIONS: Provide the name of your high school and dates of attendance. For pre-medical education and medical/osteopathic education, indicate all beginning and ending months and years of each of attendance. All gaps in the chronological progression of your training must be explained on a separate piece of paper, i.e., leave of absences, sabbaticals, taking a year off to work in order to pay for the next year of training, etc. Do not group years together, i.e., 1997 – 2001. Each year of attendance must be accounted for, or this section will be returned as incomplete.

PRE-MEDICAL EDUCATION

NAME OF COLLEGE ATTENDED	DATES OF ATTENDANCE – MONTH AND YEAR (MM/YY TO MM/YY)
	1 ST YEAR
	2 ND YEAR
	3 RD YEAR
	4 TH YEAR

MEDICAL/OSTEPATHIC EDUCATION

NAME OF MEDICAL SCHOOL ATTENDED	DATES OF ATTENDANCE – MONTH AND YEAR (MM/YY TO MM/YY)
	1 ST YEAR
	2 ND YEAR
	3 RD YEAR
	4 TH YEAR

If you attended more than four years of medical school, continue below:

	5 th YEAR
	6 th YEAR

LICENSE HISTORY

INSTRUCTIONS: Original verifications of license history certification is required for each permanent, temporary, training, provisional, or limited license obtained in any state in the US or Canadian territory, Canadian province, or US Federal jurisdiction. The issuing authority should mail the verification to the Medical Board. If licensed by examination, give the state. If licensed by reciprocity, provide the state. Provide the current status of the license: active, inactive, revoked, suspended, probation, limited, etc. You may make copies of this page if more space is needed.

STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
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CURRENT STATUS OF LICENSE	