

FORM B
REFERENCE FORM – ORTHOTIST AND PROSTHETIST LICENSURE

To Applicant: The GEORGIA COMPOSITE STATE BOARD OF MEDICAL EXAMINERS requires completion of TWO (2) references. Formal letters of reference are not accepted in lieu of the Reference Form since questions on the form are required by the Board. Have the reference sources complete the form and send it directly to **you**. **Do not open the envelope**; send it with your application packet. **Altered envelopes which contain official, original, certified official documents will not be accepted.**

Please mail your form with your application packet to:

Georgia Composite State Boards of Medical Examiners
ATTENTION: ORTHOTIST AND PROSTHETIST LICENSURE
2 Peachtree Street, NW - 36th Floor
Atlanta, GA 30303

In addition, the reference forms must come from the following individuals:

- a. **1 reference from current or former patients for each respected discipline. Custom molded devices, foot orthotist/shoes do not qualify.**
- b. **1 reference from referral sources (i.e., physicians, physical therapists, case managers, etc.)**
- c. **The Board does not accept faxed copies of the reference form.**
- d. **Please be specific of the type of orthoses or prosthesis provided or referred.**

Applicant, be sure to indicate your name and address below for identification purposes.

NAME OF APPLICANT: _____

ADDRESS: _____

CITY, STATE AND ZIP CODE: _____

To Reference Source: Please complete this form, sign, and return to the **applicant** in a **sealed envelope** at the above stated address. Your response is confidential, pursuant to Georgia law. All applicants are required to sign a general release, which relieves anyone of any liability for information furnished in good faith. Please print or type all information. Please make sure the applicant's name is indicated on the form. **Sign your name across the back of the envelope.** The processing time for licensure directly depends on timely receipt of critical forms such as this.

ATTENTION: *The person who signs this form **MAY NOT** be related to the applicant by blood, marriage, or adoption, unless the person is your current employer.*

THIS POINT FORWARD IS TO BE COMPLETED BY THE REFERENCE SOURCE:

Please **print legibly**:

From: _____
First Middle Initial Last Degree

Address City State Zip

Area code Phone Number

Area code FAX Number Date

FORM B - CONTINUED
REFERENCE FORM – ORTHOTIST AND PROSTHETIST LICENSURE

PLEASE CONFIRM THAT THE FOLLOWING RESPONSES ARE CORRECT BEFORE SUBMITTING THIS FORM.
INAPPROPRIATE ANSWERS WILL RESULT IN A DELAY IN PROCESSING THE APPLICATION.

Standard Questions

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you ever received reports of poor clinical practice by this individual, or have you discussed concerns you had about this individual? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever received reports of poor relationships between this individual and other members of the clinical staff? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you aware of any derogatory information about this individual with respect to his/her ability to practice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does this individual have, or has this individual had in the past, any mental or physical illnesses or personal problems that interfere with his/her practice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has this individual ever abused alcohol or drugs or shown signs of chemical dependency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you aware of any lawsuits having to do with his/her practice that this individual has either lost or settled out of court? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you aware of any restrictions, limitations or other actions of any nature taken against this individual by a health related entity? | <input type="checkbox"/> | <input type="checkbox"/> |

Personal Information

1. What type of device did this individual provide for you, or what did you receive?

2. How long have you known this practitioner? _____

3. Please explain your relationship to this practitioner.

4. In what capacity has this person worked with you?

5. Describe your experience with this person.

6. Would you refer someone to this practitioner for treatment? ___YES ___NO

7. Do you recommend this individual for unrestricted licensure in Georgia? ___YES ___NO

SIGNATURE

DATE

Phone

FAX