

CERTIFICATION INFORMATION

5. Have you successfully passed the ABC examination in the applied discipline?

YES NO

DATE OF EXAMINATION: _____

LICENSE HISTORY

INSTRUCTIONS: If you are now or have ever been licensed to practice as an Orthotist or Prosthetist in another state, 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. Please complete FORM C and forward to the issuing State to request verification be sent "directly" to the Medical Board.

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)

LICENSED BY

CURRENT STATUS OF LICENSE

NAME: _____

SS#: _____

APPLICANT QUESTIONNAIRE

INSTRUCTIONS: If you answer, "YES" to questions 1-12, 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 may result in criminal penalties, up to and including reporting to the Health Integrity and Protection Databank (HIPDB).	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 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, permit or a license?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has any licensing Board or agency ever taken disciplinary action against you?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has any licensing Board or agency ever refused you renewal of a certificate, permit or a license?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been denied membership in or in any way sanctioned by any Orthotics and/or Prosthetics association, society, or specialty society?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever voluntarily surrendered a license, permit or certificate?	<input type="checkbox"/>	<input type="checkbox"/>
9. 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"/>
10. Do you have any applications for licensure or certification pending before any other licensing Board or agency?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been convicted of Medicaid or Medicare fraud, or had any restrictions as a Medicaid or Medicare provider?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you in default on a state or federally funded and/or guaranteed school loan?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you been practicing prior to reinstating your application?	<input type="checkbox"/>	<input type="checkbox"/>
14. Since your license has been on an inactive status or expired, what medical activities and continuing medical education activities have you been engaged in? _____ _____		

APPLICANT WORK HISTORY - Orthotist and Prosthetist

Please complete your work history only as it relates to the practice of orthotics and/or prosthetics.

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. You must account for all breaks in work history, including volunteer work and periods of unemployment.				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 EMPLOYMENT/ATTENDANCE: FROM: ____/____/____ MONTH DAY YEAR		% HOURS WORKED PER WEEK: ____ Clinical (DIRECT PATIENT CARE) ____ Technical (FABRICATION)		
TO: ____/____/____ MONTH DAY YEAR		TYPE OF EMPLOYMENT: ___FULL-TIME ___PART-TIME		
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 EMPLOYMENT/ATTENDANCE: FROM: ____/____/____ MONTH DAY YEAR		% HOURS WORKED PER WEEK: ____ Clinical (DIRECT PATIENT CARE) ____ Technical (FABRICATION)		
TO: ____/____/____ MONTH DAY YEAR		TYPE OF EMPLOYMENT: ___FULL-TIME ___PART-TIME		
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 EMPLOYMENT/ATTENDANCE: FROM: ____/____/____ MONTH DAY YEAR		% HOURS WORKED PER WEEK: ____ Clinical (DIRECT PATIENT CARE) ____ Technical (FABRICATION)		
TO: ____/____/____ MONTH DAY YEAR		TYPE OF EMPLOYMENT: ___FULL-TIME ___PART-TIME		

AFFIDAVIT OF APPLICANT

<p>PHOTO AREA PASTE A 2 ¼" X 3" PHOTO HERE.</p> <p>PHOTO MUST BE OF YOUR HEAD AND SHOULDER AREAS ONLY</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">TOP OF PHOTO (HEAD)</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">BOTTOM OF PHOTO (SHOULDERS)</p>
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Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies.

I acknowledge and state that I have read the Application for Orthotist and Prosthetist Licensure Information and Applicant instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Orthotics and Prosthetics Practice Act, and the Board Rules.

I further state that by filing this application for license to practice orthotics and prosthetics in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to practice. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I request and authorize any treatment program to release alcohol and drug abuse patient records to the Composite State Board of Medical Examiners for the purpose of evaluating my fitness to practice. The consent of this paragraph is subject to revocation pursuant to federal regulations and terminates upon the date of termination of licensure in Georgia.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or International), court, association, institution, or other organization having control of my documents, records and other information pertaining to me, to furnish to the Georgia Composite State Board of Medical Examiners any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Composite State Board of Medical Examiners or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice there under.

I authorize and request the Georgia Composite State Board of Medical Examiners to obtain any criminal history information concerning me from any authorized law enforcement agency, including but not limited to the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC).

I hereby release, discharge, and exonerate the Georgia Composite State Board of Medical Examiners, its agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Composite State Board of Medical Examiners.

This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that false swearing may constitute a felony offense under O.C.G.A. 16-10-71. I understand that working and falsely presenting myself to the public as licensed to practice as an orthotist and/or prosthetist is a violation of the Orthotics and Prosthetics Act and is a misdemeanor.

SIGNATURE OF APPLICANT	DATE	CITY	COUNTY	STATE
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PRINTED NAME OF APPLICANT	Being duly sworn, says that he/she is the person who executed the above application for a license to practice orthotics and prosthetics in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.	NOTARY SEAL MUST BE IMPRINTED HERE
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Sworn and subscribed to me this ____ day of _____, _____ <div style="text-align: right;">(Notary Public)</div>	My Commission Expires _____
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