



Log in any time to check your application status at <http://tinyurl.com/MedicalBoardLogin>. Or scan here:

**Initial Physician Licensure (Graduate of Medical School in U.S. or Canada)  
Applicants Applying By Mail**

**Thank you for submitting your application!** Within 7 business days after we have received your completed application and payment, your Applications Specialist will review your application and update your online checklist. You can use this checklist and the attached forms to get started now. If you have a GCMB Online account, you can log in to check your updated application status online any time, day or night. If you do not have a GCMB Online account, ask us to create one for you. **(Note: If you have already sent some or all of these documents to us, you may not need to send them again.)**

**Submit the following items to us as soon as possible. They are required of all applicants.**

- Application and Application Fee (\$500.00)**
- Your current CV or resume** (also, provide information for any date gaps in the CV or resume).
- Form B**, Reference Form (three references are required).
- Form D**, Affidavit of Applicant.
- Form D2**, Affidavit for Medical Board License (original form; must be notarized).
- A copy of a secure and verifiable document** from the list following Form G.
- Form E**, Malpractice Questionnaire, including documentation of any cases.

**Submit the following items if you are not using Federation Credentials Verification Service (<http://www.fsmb.org/fcvs.html>).**  
**FCVS users: You do not need to send us these items. They will be provided to the Board by FCVS.**

- Official medical transcript**, issued to the Georgia Composite Medical Board. We must receive this either directly from the school, or in an unaltered, unopened, sealed envelope. If it is not in English, include a certified copy of English translation.
- Official licensing examination score transcript**, issued to the Georgia Composite Medical Board. We must receive this directly from the agency providing the transcript or report. *You can order USMLE and other national exam score transcripts at <http://www.fsmb.org/transcripts.html>.*
- Form A**, Certificate of Postgraduate Training, for each training program you have participated in. We must receive this either directly from the school, or in an unaltered, unopened, sealed envelope.

**Submit the following items, if applicable. (Note: Some circumstances may require items not listed here.)**

- National Practitioner Data Bank (NPDB) and Health Integrity and Protection Data Bank (HIPDB) Self-Query and Reports**, if you have ever held a license in the US or Canada (not including training licenses). You can order it at [https://www.npdb-hipdb.hrsa.gov/ext/RulesOfBehaviorSQ.jsp?SUBJECT\\_TYPE=I](https://www.npdb-hipdb.hrsa.gov/ext/RulesOfBehaviorSQ.jsp?SUBJECT_TYPE=I).
- Official license verification** from each state, territory, or province of the U.S. or Canada in which you have held any type of medical license, including training, limited, or restricted licenses. We must receive this directly from the licensing authority or from Veridoc ([www.veridoc.org](http://www.veridoc.org)). Contact information for other licensing authorities can be found at [http://www.fsmb.org/directory\\_smb.html](http://www.fsmb.org/directory_smb.html).
- Military discharge documentation**, if you have ever been discharged from US military service.
- Explanations and documentation** concerning any arrests, convictions, disciplinary actions, licensure denials, etc.
- Form G**, Specific Power of Attorney, if you want to authorize anyone else to make inquiries about your application.

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**If your last name starts with:**

**Your Applications Specialist is:**

**Contact details:**

**A through G**

Katonya Reynolds

404-463-6162; [kreynolds@dch.ga.gov](mailto:kreynolds@dch.ga.gov)

**H through O**

Candis Dickerson

404-657-6491; [cdickerson@dch.ga.gov](mailto:cdickerson@dch.ga.gov)

**P through Z**

Deborah Bruce

404-656-7067; [dbruce@dch.ga.gov](mailto:dbruce@dch.ga.gov)

**Licensure Unit Manager: Carol Dorsey (404-651-7854; [cdorsey@dch.ga.gov](mailto:cdorsey@dch.ga.gov))**





## Applicant Questionnaire:

YES NO

**“Yes” responses require a personal explanation and supporting documentation.**

1. During the last 7 years, have you suffered from any physical, psychiatric, or substance use disorder that could impair or require limitations on your functioning as a professional or has resulted in the inability to practice medicine for more than 30 days, or required court-ordered treatment or hospitalization? (If yes, provide treatment history documentation to include diagnosis, treatment regimen, hospitalization, and ongoing treatment/medication to the Board. **NOTE: If you are currently enrolled in GAPHP, you may check NO.**

2. Have you entered a plea bargain, been arrested, indicted or convicted for violating any state or federal law including DUI (excluding minor traffic violations)? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding, regardless of whether the adjudication of guilt or sentence is withheld or not entered.

3. Have you ever been denied the privilege of taking an examination given by any licensing Board or Agency?

4. Has any licensing Board or agency ever taken a **public or private** disciplinary action against you?

5. Has any licensing Board or agency ever refused you renewal of a certificate or a license?

6. Have you ever been denied a DEA registration number?

7. Have you ever been issued a restricted DEA registration?

8. Are you currently registered with the DEA?

If yes, provide DEA number \_\_\_\_\_ and State of Issue \_\_\_\_\_

9. Have you ever been named as a party in a malpractice suit, arbitration hearing, State Review panel proceeding, or a VA/Federal agency review?

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?

11. Have you ever been denied membership in, or in any way sanctioned, by any medical or osteopathic association, society, or specialty society?

12. Have you ever surrendered a medical license?

13. Have you ever surrendered a controlled substance registration?

14. Have you ever surrendered a DEA registration?

15. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?

16. Do you have any applications for licensure pending before any other licensing Board or agency? If yes, provide a list.

17. Have you ever had any restrictions as a Medicaid or Medicare provider?

18. Are you in default on a state or federally funded and/or guaranteed school loan?

19. Are you in default on child support payments?

20. Do you intend to practice medicine in Georgia? Please provide your plans below:



## Program Questions

1. What examinations have you taken?      USMLE      NBME      COMLEX      \_\_\_\_\_ State Board (Specify)  
    LMCC      FLEX      NBOME      Structured Examination

2. How long have you lived in the US?      \_\_\_\_\_ years      \_\_\_\_\_ months

3. Have you served in the U.S. Armed Forces? If yes provide a copy of Military Discharge Paperwork      Yes      No

4. Are you Board certified in your specialty?      Yes      No  
 If yes, provide specialty \_\_\_\_\_

5. Will you be using FCVS?      Yes      No

6. Are you a US Citizen?      Yes      No

If you are not a U.S. citizen, you must submit documentation that will determine if you have a qualified alien status. **Only those applicants who can provide proof will be granted a license.** The Board participates in the **DHS-USCIS SAVE** (Systematic Alien Verification for Entitlements or "SAVE") program for the purpose of verifying citizenship and immigration status information of non-citizens. In order to confirm your status with the SAVE program, you need to provide the board with **legible** copies of **one** of the documents on the enclosed list.

### License History

Provide history for each permanent, temporary, training, provisional, or limited licensed obtained in any state in the US, Canadian Territory or Province, or US Federal Jurisdiction.

|               |       |                |       |               |       |
|---------------|-------|----------------|-------|---------------|-------|
| <b>State</b>  | _____ | <b>Country</b> | _____ | <b>Status</b> | _____ |
| <b>Issued</b> | From: | (mm/dd/yy)     | To:   | (mm/dd/yy)    |       |
| <hr/>         |       |                |       |               |       |
| <b>State</b>  | _____ | <b>Country</b> | _____ | <b>Status</b> | _____ |
| <b>Issued</b> | From: | (mm/dd/yy)     | To:   | (mm/dd/yy)    |       |
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| <b>Issued</b> | From: | (mm/dd/yy)     | To:   | (mm/dd/yy)    |       |
| <hr/>         |       |                |       |               |       |



### License History (continued)

|                           |                      |                     |
|---------------------------|----------------------|---------------------|
| <b>State</b> _____        | <b>Country</b> _____ | <b>Status</b> _____ |
| <b>Issued</b> From: _____ | (mm/dd/yy) To: _____ | (mm/dd/yy)          |
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| <b>State</b> _____        | <b>Country</b> _____ | <b>Status</b> _____ |
| <b>Issued</b> From: _____ | (mm/dd/yy) To: _____ | (mm/dd/yy)          |
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| <b>State</b> _____        | <b>Country</b> _____ | <b>Status</b> _____ |
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| <b>State</b> _____        | <b>Country</b> _____ | <b>Status</b> _____ |
| <b>Issued</b> From: _____ | (mm/dd/yy) To: _____ | (mm/dd/yy)          |
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| <b>State</b> _____        | <b>Country</b> _____ | <b>Status</b> _____ |
| <b>Issued</b> From: _____ | (mm/dd/yy) To: _____ | (mm/dd/yy)          |
| <hr/>                     |                      |                     |



## Medical/Osteopathic Education

### **Pre-medical Education**

Beginning month and ending year for each year of attendance is required.

#### **College**

|                  |                     |                   |
|------------------|---------------------|-------------------|
| <b>1st. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>2nd. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>3rd. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>4th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>5th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>6th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>7th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>8th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>9th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |

### **Medical Education**

Beginning month and ending year for each year of attendance is required.

#### **Medical School**

|                  |                     |                   |
|------------------|---------------------|-------------------|
| <b>1st. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>2nd. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>3rd. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>4th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>5th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>6th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>7th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>8th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |
| <b>9th. Year</b> | From: _____ (mm/yy) | TO: _____ (mm/yy) |

### **Post Graduate Training**

**Specialty** \_\_\_\_\_

**Hospital** \_\_\_\_\_

**Address** \_\_\_\_\_

**City/State/Zip** \_\_\_\_\_

**Specialty** \_\_\_\_\_

**Hospital** \_\_\_\_\_

**Address** \_\_\_\_\_

**City/State/Zip** \_\_\_\_\_

Attach more pages if you have more to list.



## Hospital Privileges

Have you ever held any hospital privileges?

Yes

No

*Hospital*

---

*Address*

---

*City/State/Zip*

---

---

*Hospital*

---

*Address*

---

*City/State/Zip*

---

Attach more pages if you have more hospitals to list

# FORM A

## CERTIFICATE OF POSTGRADUATE TRAINING

**INSTRUCTIONS:** To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Either the hospital seal OR notary seal must be on this form. Errors shall be noted by one line through the error and initials of correcting party. No whiteouts or strikeouts are acceptable on this form and may result in a delay of the application process. This form may be sent with the applicant's application packet only if the original envelope is unopened, and the program director has signed his/her name across the back of the envelope. Altered envelopes which contain official, original, or certified official documents will not be accepted.

### PART 1: TO BE COMPLETED BY THE APPLICANT.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

### PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR.

Every effort should be made by the training program to complete this form as accurately as possible. However, the Georgia Composite Medical Board does understand that programs close and facilities merge making records unavailable. The Federation of State Medical Boards has offered all [Accreditation Council of Graduate Medical Education](#) approved programs which have closed the opportunity to permanently store their resident records. Additionally, a few [American Osteopathic Association](#) approved programs and other training programs have sent resident records to the Federation. This will provide a central repository for those entities requiring verification of physicians' credentials.

**US and Canadian Medical School Graduates:** Please provide the training dates. If the program is in progress, you may provide the "to" date as the date which the training is scheduled to be completed. This will provide the current standing of the training.

**International Medical School Graduates:** Do not complete this form unless the training requirement has been completed. As of February 5, 2010, the Georgia Composite Medical Board voted to utilize the *Medical Schools Recognized by the Medical Board of California* (MSRMBC) as its official reference for approval of medical schools outside the US and Canada. The list may be viewed online at <http://www.mbc.ca.gov/applicant/schools.html> Graduates are required to complete training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) as follows:

- If school is recognized by MSRMBC, one year (1) year
- If school is not recognized by MSRMBC, three (3) years

Please print, type or stamp the following information:

Name of Program: \_\_\_\_\_  
 Sponsored by: \_\_\_\_\_  
**Program ID:** \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Affiliated University: \_\_\_\_\_

| Georgia Composite Medical Board Use Only |       |
|--|-------|
| AMA                                      | _____ |
| AOA                                      | _____ |
| RCPSC                                    | _____ |
| CFPC                                     | _____ |

It is further certified that this program is accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Council on Postdoctoral Training (ECCOPT), RCPSC, or CFPC for the training of medical and osteopathic interns, residents, fellowships, and research as an Accredited Program, Graduate Medical Education Teaching Institution, or Osteopathic Postdoctoral Training Program. This is to certify that the applicant name in Part 1 has completed, not completed, or the training is in progress as follows:

|  |            |     |    |             |
|--|------------|-----|----|-------------|
| Internship from ___/___/___ to ___/___/___ Specialty/subspecialty _____      | Completed: | Yes | No | In Progress |
| Residency from ___/___/___ to ___/___/___ Specialty/subspecialty _____       | Completed: | Yes | No | In Progress |
| Chief Residency from ___/___/___ to ___/___/___ Specialty/subspecialty _____ | Completed: | Yes | No | In Progress |
| Fellowship from ___/___/___ to ___/___/___ Specialty/subspecialty _____      | Completed: | Yes | No | In Progress |
| Research from ___/___/___ to ___/___/___ Specialty/subspecialty _____        | Completed: | Yes | No | In Progress |

If "YES" to any of the following questions, please provide a written explanation and supporting documentation:

|  |     |    |
|--|-----|----|
| Any leave of absences requested/reported?  | Yes | No |
| Any probationary action ever taken?  | Yes | No |
| Any disciplinary actions or investigations?  | Yes | No |
| Any special requirements or limitations due to questions of academic incompetence, disciplinary problem, etc | Yes | No |

Completion of this form will certify that the individual named in Part 1 above completed a period of accredited postgraduate training at this facility. This form shall be signed by the Program Director (MD or DO only).

Program Director's Name \_\_\_\_\_

Notary's Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Notary Signature \_\_\_\_\_

Affix the institutional seal in this space. If you have no seal available, you are required to have this form notarized.



**FORM B - CONTINUED**  
**REFERENCE FORM – INITIAL PHYSICIAN LICENSURE**

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

**If you answer "YES" to questions 1-7, please provide an explanation.**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Have you ever received reports of poor medical practice by this physician, or have you discussed concerns you had about this physician's practice with medical staff officers at a hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever received reports of poor relationships between this physician and other members of hospital staff?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does this physician have, or has this physician had in the past, any mental or physical illnesses or personal problems that interfere with his/her medical practice?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has this physician 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 medical practice that this physician 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 physician by a hospital or other health related entity?                                     | <input type="checkbox"/> | <input type="checkbox"/> |

**If you answer "NO" to questions 8-11, please provide an explanation.**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 8. Does this physician accept medical staff and hospital policies and function willingly according to these policies?      | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does this physician enjoy professional respect among his/her colleagues and in the community where applicant practices? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you sorry to see this physician leave your community?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you recommend this physician for unrestricted medical licensure in Georgia?   | <input type="checkbox"/> | <input type="checkbox"/> |

If you have any comments regarding this applicant, please put your response in writing and attach it to this form. Please sign, provide your title, name of hospital if applicable and the date.

\_\_\_\_\_  
**SIGNATURE**

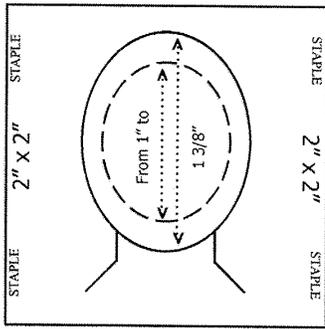
\_\_\_\_\_  
**TITLE**

\_\_\_\_\_  
**HOSPITAL (IF APPLICABLE)**

\_\_\_\_\_  
**DATE**

Name: \_\_\_\_\_ Social Security Number : \_\_\_\_\_

# FORM D AFFIDAVIT OF APPLICANT



Attach Passport Photo Here

**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 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 Medical Practice Act and the Board Rules, copies of which are sent to applicants.

I further state that by filing this application for license to practice medicine in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. 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 Georgia Composite Medical Board 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 medical 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 Medical Board 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 Medical Board 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 Medical Board 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 Medical Board, 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 Medical Board.

This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that pursuant to the Official Code of Georgia Annotated, Section 43-34-46, any person who shall give false or forged evidence of any kind to the Board in connection with an application for a license to practice medicine shall be guilty of a felony and upon conviction thereof, shall be punished by a fine of not less than \$500.00 nor more than \$1,000.00, or by imprisonment from two to five years, or both.

Applicant's Name: \_\_\_\_\_

Application Date: \_\_\_\_\_

Date the application was executed; may differ from date this affidavit was notarized

Signature of Applicant: \_\_\_\_\_

Being duly sworn, says that he/she is the person who executed the application for a license to practice medicine and surgery in the State of Georgia; that all the statements herein contained are true in every respect; and that the attached photo is a true photo of the applicant.

Affix the Notary Seal/Stamp In this space.

Sworn and subscribed to me this \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_.

Signature of Public Notary: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

O.C.G.A. § 50-36-1(e)(2) Affidavit for Medical Board License - INITIAL APPLICATION ONLY

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, from the Georgia Composite Medical Board, the undersigned applicant verifies one of the following with respect to my application for a public benefit:

- 1. I am a United States citizen.
2. I am a legal permanent resident of the United States.
3. I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security.
My alien number issued by the Department of Homeland Security is:
4. I am NOT a citizen of the United States, and am NOT physically present in the United States. (See note in instructions below).

I am 18 years of age or older and have provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit. In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in (city), (state).

SIGNATURE OF APPLICANT

NAME OF APPLICANT (PRINT)

LICENSE TYPE APPLYING FOR (check one):

- 1101 - PHYSICIAN ASSISTANT
1104 - PHYSICIAN
1106 - RESPIRATORY CARE PROFESSIONAL
1109 - ACUPUNCTURIST
1112 - CLINICAL PERFUSIONIST
1114 - TEMPORARY RESIDENCY TRAINING PERMIT
1115 - ORTHOTIST
1116 - PROSTHETIST
1117 - ORTHOTIST/PROSTHETIST (DUAL)
1119 - ASSISTANT COSMETIC LASER PRACTITIONER
1120 - SENIOR COSMETIC LASER PRACTITIONER
OTHER (SPECIFY):

INSTRUCTIONS TO APPLICANT:

- 1. Be sure to submit the correct type of document with this affidavit. If you are not a citizen of the United States, you must submit a copy of a document we can use to verify your lawful presence, such as your U.S. Permanent Resident Card, foreign passport with I-94 attached, etc. If you are a U.S. citizen, you may submit a copy of your U.S. passport, driver's license, birth certificate, etc.
2. Mail this original affidavit and a copy of at least one acceptable verifiable document to
GA COMPOSITE MEDICAL BOARD,
2 PEACHTREE ST NW, 36TH FLOOR
ATLANTA GA 30303.

Note: If you checked #4 to indicate that you are not a US citizen and are not physically present in the US, submit the affidavit (without any other document) only.

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE

DAY OF, 20

NOTARY PUBLIC
My Commission Expires:

# FORM E

## MALPRACTICE QUESTIONNAIRE

**INSTRUCTIONS:** Complete, sign, and date this Questionnaire. Complete a separate form for each case in which you have ever been named as a defendant, even if you have been dismissed or even if the case is still pending. You must attach the appropriate documentation from the courts and mail it to the Board. Do not take shortcuts on documenting malpractice. You must give a detailed summary of your actual involvement in the treatment of the patient. Failure to do so can result in delays in the processing of your application. Summaries by your attorney or your insurance company are not accepted in lieu of this documentation. The Georgia Composite Medical Board requires a copy of the Plaintiff's Complaint, and either the Settlement Agreement, Dismissal Order or Summary Judgment. Copies can be your own, or obtained either from your attorney or county clerk's office, and must be 8-1/2" by 11" in size. Do not submit two-sided copies.

Full Name of Physician \_\_\_\_\_

Business Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

None. If none, please complete information above. Then, sign and date the form and mail it to the Board.

Name of Patient: \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Age of Patient \_\_\_\_\_ Years

Date of Occurrence: \_\_\_\_\_

Location of Incident: \_\_\_\_\_

Site \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

County \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Position in Case:  Intern  Resident  Primary Physician  Other: \_\_\_\_\_

Filed Against:  Individual Physician  Group  Hospital

List Names of Other  
Physicians/Hospitals: \_\_\_\_\_

Attach to this document a detailed, typewritten summary of the circumstances surrounding the incident and your involvement in your own words. Do not reference other documents – include them with the summary. Even if the incident occurred while you were an intern or resident, a summary must accompany this form.

Disposition:  Pending  Settled  Dismissed

If settled, provide the following information:  In Court  Out of Court Date of settlement: \_\_\_\_\_

Total Amount of Settlement: \$ \_\_\_\_\_ Amount Attributable to you: \$ \_\_\_\_\_

\*\*\*\*\* IMPORTANT: THIS FORM IS INVALID WITHOUT YOUR SIGNATURE AND SIGNATURE DATE. \*\*\*\*\*

SIGNATURE (REQUIRED)

DATE SIGNED

**FORM G  
SPECIFIC POWER OF ATTORNEY**

I, \_\_\_\_\_, do hereby authorize and direct \_\_\_\_\_ and  
Applicant's full name Company or designated agent's name  
 its agents and employees, by this Specific Power of Attorney to carry out and execute certain duties pursuant to  
 my request and necessary in \_\_\_\_\_'s reasonable judgment in connection with  
Company or designated agent's name  
 my pursuit of a license to practice medicine in the State of Georgia ("Licensed State").

It is expressly understood and agreed that this Specific Power of Attorney authorizes \_\_\_\_\_ to  
Company or designated agent's name  
 make inquiries as to the status of my application for a medical license in the Licensed State. This Specific Power  
 of Attorney does not authorize \_\_\_\_\_ to act on my behalf for any other purpose  
Company or designated agent's name  
 and shall expire on the date I am granted a license in the Licensed State, the date my application for a medical  
 license is denied, or upon \_\_\_\_\_'s receipt of written notice from me of  
Company or designated agent's name  
 revocation of this Specific Power of Attorney.

I hereby release \_\_\_\_\_ and the Licensed State from any and all liability,  
Company or designated agent's name  
 damages, claims for damages, suits, actions and causes of action which may accrue as a result of  
 \_\_\_\_\_ acting on my behalf in connection with my pursuit of a medical license  
Company or designated agent's name  
 in the Licensed State.

|  |   |  |
|--|---|--|
| _____<br>PRINTED NAME OF APPLICANT<br><br>_____<br>SIGNATURE OF APPLICANT      | Being duly sworn, says that he/she is the person who executed the above application for a license to practice medicine and surgery in the State of Georgia; and that all the statements herein contained are true in every respect. |  |
| Sworn and subscribed to me this ____ day of _____,<br>_____<br>(Notary Public) | My Commission Expires<br>_____  | NOTARY<br>SEAL<br>MUST<br>BE IMPRINTED<br>HERE |

## **Secure and Verifiable Documents Under O.C.G.A. § 50-36-2**

Issued August 1, 2012 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 (“IIREA”) provides that “[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law’s website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General.” O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A driver’s license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at:  
<http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- Certification of Report of Birth issued by the United States Department of State (Form DS-1350) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- Certification of Birth Abroad issued by the United States Department of State (Form FS-545) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- Consular Report of Birth Abroad issued by the United States Department of State (Form FS-240) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- An original or certified copy of a birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]