2017-2018 INITIAL APPLICATION
GEORGIA RESIDENCY TRAINING PERMIT

The Georgia Composite Medical Board will discuss the application status with the applicant and Program Director/GME Designee ONLY associated with the temporary training permit.

Once an application for a residency-training permit has been received, staff must complete the initial review within **30** days. Notification is sent in **writing** to the GME Office with the application status and an itemized list of documents needed to complete the file (if required.)

CHECKLIST

_____ Complete **Application Pages 1-2**

- On page 1 – If you don't have a US Social Security Number, you may leave it blank for now. If your new visa documentation is not yet available, submit what you have with the permit application packet and forward your updated visa documentation as soon as it is received. The state board will process your application and place it on pending status until your relevant visa documentation is received.
- On page 2 – If any YES answers, provide appropriate statement(s)/documentation. Each **"Yes" answer requires a written statement explaining the circumstances**. Attach your explanation and copies of any official documentation. Examples include: arrest record, final disposition of arrest, or treating physician documentation. Previous residency completion certificate or letter of good standing can be obtained from your program coordinator. Make sure all documents are **LEGIBLE**.

_____ Complete Page 3 - **Form A** - Affidavit of Applicant Form. Original signatures required. Form must be notarized and *the Applicant Date and the Notary Date MUST match*. A passport-sized/type photograph is required.

_____ Complete Page 4 - **Form A1** – Notarized Affidavit for Medical Board License Form. Submit the appropriate documentation to show lawful presence in the US. Original signatures required. This form must also be notarized.

_____ Complete the top portion of Page 5 - **Form B** - Certificate of Postgraduate Training Form. Fill out Part 1 only. Include the completed form and attachments in your return package. Your incoming program will complete Part 2 and take care of the program director signature.

_____ Submit a copy of your **medical school or osteopathic school diploma** – must be approved by the ACGME, AOA, or the LCME. (Provide English translation, if diploma is not in English.) If a copy of the diploma is not yet available, a letter from the school (on letterhead) with the expected date of graduation can be accepted.

OR

_____ Submit a copy of your **ECFMG certification** if you are a graduate of a foreign medical school. If a copy of the ECFMG certificate is not yet available, a request for a **waiver must be submitted.** Click this link

http://medicalboard.georgia.gov/petition-and-waiver-rules-information

Use only blue or black ink to complete the forms. No corrections, strike-through or white-outs are allowed. If you make a mistake access the online Orientation page and print a new form.

NOTE:

- If you already have a full Georgia Medical License, you do not need to complete this renewal. Have your program coordinator notify GME with your license information.
- If you are currently applying for a full license, you should complete the renewal form in case your full license is not received by 7/1/2017. Attach a note to inform GME about the license application.

Documentation to be submitted with the Notarized Affidavit:

If you are a U.S. citizen, provide ONE of the following:

Copy of your Current Driver's License

Copy of your current U.S. passport

Copy of your Naturalization Certificate

If you are NOT a U.S. citizen, provide the following:

Permanent Resident card – copy of the I-551 (Both FRONT and BACK of card)

Employment Authorization Card - copy of the I-766 or I-688A

J-1 Visa – copy of the DS-2019 (J-1 visa) and copy of the I-94

F-1 Visa – Copy of the I-20 (F-1 visa) and copy of the I-94

H-1-B visa – Visa Information with valid (not expired) foreign passport and I-94

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.

MAKE SURE ALL COPIES ARE LEGIBLE. Use a good quality copier and ENLARGE the size of the copy if needed. If we cannot read your documents, we will be unable to submit your information to the SAVE program, which will delay the processing of your application.

APPLICATION FOR TEMPORARY POSTGRADUATE TRAINING PERMIT

BASIC INFORMATION

INSTRUCTIONS: Provide your <u>full</u> legal name, in the format indicated on the application. This is the name that will be printed on the permit card and reported to hospitals and those who inquire about your training permit.

LAST NAME	FIRST NAME	MIDDLE NAME

MAIDEN NAME (IF APPLICABLE)	DEGREE (MD OR DO)

Other names under which material may be submitted – Do not use nicknames	

DATE OF BIRTH (MM/DD/YY)	NAME OF MEDICAL SCHOOL	GRADUATION DATE

Will you be participating in a short-term elective ROTATION OR are you a VISITING RESIDENT? _____YES _____NO
If YES, please provide <u>a letter of good standing from your current program director</u>.

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 am a U.S. Citizen**
NOTE: SUBMIT WITH THIS APPLICATION YOUR ORIGINAL NOTARIZED AFFIDAVIT (FORM A1) and VERIFIABLE DOCUMENT.

☐ **I am <u>not</u> 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.**
NOTE: SUBMIT WITH THIS APPLICATION YOUR ORIGINAL NOTARIZED AFFIDAVIT (FORM A1) and APPROPRIATE ACCEPTABLE SUPPORTING DOCUMENTATION.
The processing of your application may be delayed due to verification requirements.

<u>FOR TEMPORARY TRAINING PERMIT HOLDERS, YOUR GEORGIA GME PRACTICE ADDRESS WILL BE USED AS THE PRIMARY MAILING ADDRESS TO RECEIVE MAIL FROM THE BOARD.</u>

RESIDENCE STREET ADDRESS	APARTMENT #

CITY	STATE	ZIP CODE	COUNTY

(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)	E-MAIL ADDRESS (OPTIONAL)

Georgia GME Practice Address (MANDATORY)	**Graduate Medical Education, Emory University School of Medicine 100 Woodruff Circle**	SUITE # **327**

CITY	STATE	ZIP CODE	COUNTY
Atlanta	**GA**	**30322**	**DeKalb**

(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)	E-MAIL ADDRESS (OPTIONAL)

NAME:_____ **SS#:**_____

PRINT LEGIBLY

TEMPORARY POSTGRADUATE TRAINING PERMIT

If you answer, "YES" to any of the questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. **This includes items such as a statement from the treating physician, court documents, etc. For Questions 20-22, a letter of good standing/explanation from previous GME program(s) is required.** Failure to furnish the documentation may result in a delay in the application process.

	YES	NO
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 ever 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 denied you a certificate or a license?		
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? **(DO NOT INCLUDE INSTITUTIONAL DEA #)** If you are registered with the DEA, provide the number and state of issue below: _____ State of issue_____		
9. Have you ever had any malpractice suits filed against you?		
10. Have you ever been denied membership in or in any way sanctioned by any medical or osteopathic association, society, or specialty society?		
11. Have you ever resigned from a hospital staff position or training program after a complaint or peer review action has been initiated against you?		
12. Have you ever voluntarily surrendered a medical license?		
13. Have you ever voluntarily surrendered a controlled substance registration?		
14. Have you ever voluntarily surrendered a DEA registration?		
15. To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?		
16. Do you have any applications for licensure pending before any other licensing Board or agency?		
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. Have you ever transferred from one graduate medical education program to another? **If yes, attach documentation.**		
21. Have you ever been terminated from a graduate medical education program? **If yes, attach documentation.**		
22. Have you ever resigned from a graduate medical education program? **If yes, attach documentation.**		

NAME:_____ SS#:_____

PRINT LEGIBLY

FORM A
Temporary Postgraduate Training Permit
AFFIDAVIT OF APPLICANT

TOP OF PHOTO (HEAD)

PHOTO AREA
PASTE A 2 ¼" X 3"
PHOTO HERE.

PHOTO MUST BE OF
YOUR HEAD
AND SHOULDER AREAS ONLY

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 would be used to determine your qualifications for a temporary postgraduate training permit 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 Temporary Postgraduate Training Permit 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 a temporary postgraduate training permit 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 my training permit 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 to the Board, its staff and their representatives, any and all documentation necessary now and in the future to evaluate my qualifications to practice medicine, including, but not limited to my moral character, professional reputation and fitness to safely practice medicine.

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.

I authorize the Georgia Composite Medical Board to release information, material, documents, or the like relating to me or to this application to any other State or Territory of the United States or Province of Canada, a law enforcement agency, hospital or other appropriate agencies as determined by the Georgia Composite Medical Board.

I hereby swear or affirm under penalties of perjury that all statements made by me in this application and any attachments hereto and made a part hereof are true and correct. 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.

I understand that I must limit my activities under the training permit to such acts as may be prescribed by or incidental to the training program, that I may train only under the supervision of physicians responsible for supervision as part of the training program, and may practice in facilities affiliated with the program only if such practice is part of the training program.

SIGNATURE OF APPLICANT **DATE** CITY COUNTY STATE

PRINTED NAME OF APPLICANT

_____

Being duly sworn, says that he/she is the person who executed the above application for a temporary postgraduate training permit 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. In addition, I will immediately notify the Board in writing of any changes to the answers to questions contained in the Applicant Questionnaire if such a change in answer is warranted at anytime, prior to being granted a temporary postgraduate training permit by the Georgia Composite Medical Board.

NOTARY SEAL MUST BE IMPRINTED HERE

My Commission Expires

_____

Sworn and subscribed to me this _____day of _____, 20_____.

_____(Notary Public)

FORM A(1)

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

Name of Resident: _____

PRINT LEGIBLY

Institution Name: Emory University School of Medicine

Residency Program Name (Enter your Incoming Emory Program Name**):** _____

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: (**SELECT ONLY ONE**.)

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 or other federal immigration agency. My alien number issued by the Department of Homeland Security or other federal immigration agency is:

_____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

REQUIRED: The secure and verifiable document provided with this affidavit can best be classified as:

_____.

U.S. citizens – U.S. passport, driver's license, or certificate of naturalization
NON-US citizens - I-551, I-766/I-688A, J-1 visa, F-1 visa, H1B visa, I-94 – all that apply

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).

Residency Training Permit
1114 – License Type

_____
Signature of Applicant

_____
Printed Name of Applicant

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE

_____ DAY OF _____, 20_____

_____
NOTARY PUBLIC

My Commission Expires: _____

FORM B
CERTIFICATE OF POSTGRADUATE TRAINING FORM

INSTRUCTIONS: Complete all items, including all required documentation, signatures, and seals.

PART 1: To be completed by the Applicant

LAST NAME **FIRST NAME** **MIDDLE INITIAL**

DATE OF BIRTH	TELEPHONE NUMBER HOME: WORK:

GEORGIA GME PRACTICE ADDRESS:

Graduate Medical Education, Emory University School of Medicine, 100 Woodruff Circle, Suite 327

CITY	STATE	ZIP CODE
Atlanta	**GA**	**30322**

PART 2: To be completed by the Incoming Program Director

TYPE OF PROGRAM: CIRCLE THE YEAR OF TRAINING

PGY1 PGY2 PGY3 PGY4 PGY5 PGY6 PGY7

Name of Training Program (i.e., Internal Medicine, Psychiatry) _____

Beginning date of training in GA program:	Projected Completion Date in GA program:	

This section must be completed by the Program Director (Incoming Program) who is licensed in Georgia.

PROGRAM DIRECTOR'S AFFIDAVIT

I hereby recommend the above applicant be granted a postgraduate training permit. I hereby certify that he/she will limit his/her practice to such acts as may be prescribed by or incidental to the training program, that he/she may train only under the supervision of physicians responsible for supervision as part of the training program and may practice in facilities affiliated with the program only if such practice is part of the training program for which the permit is granted. I hereby recommend the above applicant be granted a postgraduate training permit. I hereby certify that he/she will limit his/her practice to such acts as may be prescribed by or incidental to the training program, that he/she may train only under the supervision of physicians responsible for supervision as part of the training program and may practice in facilities affiliated with the program only if such practice is part of the training program for which the permit is granted. **I understand that I must report to the Board the following within 15 days of the event: any disciplinary action taken against the permit holder for any ground or violation enumerated in O.C.G.A. §§ 43-34-37 and 43-1-19, the permit holder's withdrawal or termination from or completion of a postgraduate training program or the permit holder leaving the program for any length of time in excess of two weeks. I HEREBY RECOMMEND THE ABOVE APPLICANT FOR ADVANCEMENT TO THE NEXT LEVEL AS REQUIRED IN 360-2-.12(4).**

Please type or print:

_____

Program Director's Name Title

_____ _____

Signature **Date**

HOSPITAL SEAL OR NOTARY STAMP MUST BE IMPRINTED HERE

Sworn to and subscribed before me this

_____ day of _____, 20_____.
DATE MONTH YEAR

SIGNATURE OF NOTARY PUBLIC

_____

EXPIRATION STAMP must be stamped here