APPLICATION
EDUCATIONAL TRAINING CERTIFICATE

ATTACH FEE HERE

GEORGIA COMPOSITE MEDICAL BOARD (GCMB) USE ONLY

AP NUMBER	_____	**FILE NUMBER**	_____
RECEIVED	_____	**COMPLETED**	_____
CERTIFICATE#	_____	**Issue Date**	_____
		Expiration Date	_____
WITHDRAWN	_____	**DATE WITHDRAWN**	_____
DENIED	_____	**DATE DENIED**	_____

F E E S A R E S U B J E C T T O C H A N G E

BASIC INFORMATION

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

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

MAIDEN NAME	SEX M F	DATE OF BIRTH (MM/DD/YY)	NAME OF MEDICAL SCHOOL

_____ **I am a U.S. Citizen**

_____ **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. (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

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

APPLICANT QUESTIONNAIRE

INSTRUCTIONS: If you answer, "YES" to questions 1-9, 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 43-34-08 and may result in criminal penalties, up to and including reporting to the NPDB.	**YES**	**NO**
1. During the last seven years, were you treated for alcohol, mental or physical disorder, chemical drug dependency, neurologic, or psychiatric illness that required outpatient evaluation or inpatient hospitalization? (If yes, provide treatment history documentation to include diagnosis, treatment regimen, hospitalization, and ongoing treatment/medication to the Board any licensing Board or agency ever denied you a certificate or a license?	❑	❑
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.ave you ever been arrested for, and/or convicted of, a violation of any Federal (including military), State or Local statute?	❑	❑
3. Has any licensing Board or agency ever taken a **public or private** disciplinary action against you?	❑	❑
4. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	❑	❑
5. Have you ever been disciplined by any licensing Board or agency?	❑	❑
6. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	❑	❑
7. Have you ever had any restrictions as a Medicaid or Medicare provider?	❑	❑
8. Are you in default on a state or federally funded and/or guaranteed school loan?	❑	❑
9. Are you in default on child support payments?	❑	❑
10. Did you include a copy of your CV or résumé with this application packet?	❑	❑

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

BOTTOM OF PHOTO (SHOLDERS)

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 Educational Training Certificate Licensure Information and Applicant instructions that accompanied this application and I have answered all questions in compliance with these instructions. I further acknowledge that it is my responsibility to read and become familiar with the Medical Practice Act and Board's rules and regulations.

I further state that by filing this application 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 participate and 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 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 43-34-42, 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.

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 license 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

Sworn and subscribed to me this _____day of _____, _____

_____(Notary Public)

My Commission Expires

_____

EDUCATIONAL CERTIFICATE REQUEST FORM

A physician licensed in another state who intends to enter into this state for the sole purpose of participating in or providing educational training that involves the provision of patient care must apply for an educational training certificate in order to provide patient care.

Educational training shall include medical education training, conference, clinics, workshops or courses.

PART I – PHYSICIAN INFORMATION

Physician Name: _____ ___MD ___DO

Address: _____

City/State/Zip: _____

Current Licensure State: _____

Date License Issued: _____

Expiration Date of License _____

PART II – PROGRAM SPONSOR INFORMATION

Name of Program Sponsor: Vein Specialists of the South and Comprehensive Vein Training

Program Title: Comprehensive Vein Training Sclerotherapy and Vein Care Preceptorship

Street Address: 556 Third Street

City/State/Zip: Macon, GA 31201

Name of Responsible Person: Rachel Berg

Email Address: rachel@veinspecialists.com

Telephone Number: (478) 743-2472

Part III – INSTRUCTOR/PROVIDER INFORMATION

Instructor /Provider Name: Kenneth E. Harper, MD

Credentials: MD

(MD/PHD, LPC, CSW, MSW, etc)

Location of the Course: 556 Third Street

City/State Zip: Macon, GA 31201

Name of the Course: Vein Care Preceptorship

Topics Covered: cosmetic sclerotherapy, venous evaluations, and surgical procedures

_____ _____

Signature Date

*If available, attach a copy of the program agenda