FORM A Exceptional Circumstances Consideration Form INSTITUTION

Pl	ease print legibly	y :			
In	stitutional Physi	cian Name Last Na			
		Last Na	ame	First Name	Middle
In	stitutional Physi	cian Specialty:			
Su (S	pervisory Overs upervisory Overs	sight Physician:_ ight means the ons	site direction o	f the supervisor w	MDDO with immediate availability.
		sory oversight ph YES	•	nn unrestricted li	cense to practice medicine in the
		sight Physician Sp			
(m	iust be same as th	at of the applicant	t physician)		
Ty	pe of Supervisio	on Being Provide	d:		
In	stitution Name:				
In	stitution Addres	S:			
City		State	Zip Co	ode	Phone Number
1.	Is this institution YES	n in a medically u	nderserved area	a?	
	If yes, please submit evidence. Such evidence should include but not be limited to: (a) Deficient physician staff to service the health care needs of the population. (b) Institution can demonstrate failed attempts to recruit licensed physicians to satisfy the deficient				
2.	Is this institution licensed by the Department of Community Health? YESNO				
3.	 Is this physician applicant a graduate of an international medical school and does not qualicensure under other provisions of Chapter 43-34-26? YESNO 		school and does not qualify for		
	(a) Applicant is	bmit evidence. So s from a war torn cas applied for polit	country.		

for a personal interview before the Board or the committ	ee.
Hospital Administrator Signature	Date Signed
Applicant Physician Signature	Date Signed

NOTE: The Board may require the physician applicant and a representative of the institution to appear

Return the completed form to: Georgia Composite Medical Board Attention: Institutional Physician Licensure 2 Peachtree Street, N.W., - 36th Floor Atlanta, GA 30301