



## GEORGIA BOARD OF NURSING

Professional Licensing Boards Division  
237 Coliseum Drive  
Macon, Georgia 31217  
Telephone: (478) 207-2440  
Fax: (877) 371-5712  
Web Site: [www.sos.georgia.gov/plb/m](http://www.sos.georgia.gov/plb/m)

### INFORMATION SHEET FOR AUTHORIZATION AS AN ADVANCED PRACTICE REGISTERED NURSE

#### GENERAL INFORMATION

**WHEN MAILING APPLICATION TO BOARD OFFICE, PLEASE MAIL IN A 9X12 ENVELOPE**  
**DO NOT STAPLE OR FOLD APPLICATION**

**Read these instructions prior to completing the application. Failure to read and follow instructions may cause unnecessary delays in processing the application.**

You **MUST NOT** engage in advanced practice nursing practice in the state of Georgia until you have a valid Georgia RN license and Georgia Board of Nursing APRN authorization.

- A. This application is for advanced practice registered nurse authorization. The applicant must submit separate applications for each APRN designation being requested. You must obtain APRN authorization from the Georgia Board of Nursing (evidenced by the specialty designation on your RN license) prior to engaging in advanced nursing practice. Receipt of an RN license without the designation indicates that you do not currently have APRN authorization.
- B. Your application and all required supporting documents should be mailed in the same package to the Board office. Please request the national certifying organization to submit verifications electronically to PLB-Healthcare3@sos.ga.gov.
- C. Answer all questions. If you leave any spaces blank it may delay the processing of your application. Indicate N/A for any blanks that are not applicable.
- D. Enclose a non-refundable fee remitted in U. S. funds by check or money order payable to the Georgia Board of Nursing. Mail to the Board office at the address on the application. A separate application with an additional fee of \$60.00 is required for each advanced practice authorization title.

#### APPLICATION INSTRUCTIONS

**Legal Name** - Your name must be consistent on this application. Your signature line must match the first, middle, and last name. If your name changes during the application process, you must request a name change in writing and provide the appropriate legal documents to support the change.

**Social Security Number** – This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. §§19-11-1 et seq. and O.C.G.A. §§20-3-295 et seq., 42 U.S.C.A. §551 and 20 U.S.C.A. §1001. It may also be disclosed to the National Practitioner’s Databank (NPDB), the Healthcare Integrity and Protection Data Bank (HIPDB), other licensing boards and other regulatory agencies for license tracking purposes.

**Date of Birth** - Please enter in “mm/dd/yyyy” format.

**Residential (Physical) Address** - A residential (physical) address is required for all licensees. You may not provide a P.O. Box for the residential address.

**Mailing Address:** A mailing address is required for all licenses. You may provide a P.O. Box for this address. If you are granted authorization, your name, license number, mailing address are public information and will be accessible on the Secretary of State's website for purposes of licensure verification, pursuant to O.C.G.A. 43-1-2 (k). You are required to notify the Georgia Board of Nursing of an address change within 30 days. Address changes may be made by visiting our website at [www.sos.ga.gov/plb](http://www.sos.ga.gov/plb). Sending a notice to the U.S. Postal Service will not fulfill this requirement.

**Telephone -** It is especially imperative that this information remain current during your entire application process.

**E-mail** – Email is the primary means to communicate application deficiencies and resolve issues with your application. It is your responsibility to update your email address with the Board office. You may process these changes at [www.sos.ga.gov/plb](http://www.sos.ga.gov/plb). Your email address will not be shared with third parties.

**Official Transcripts/Certificates** – Submit all official transcripts and program certificates with course descriptions.

**Verification of Certification** - Provide only one national certification body approved by the Georgia Board of Nursing. Complete the required portion and send the attached Verification of Certification to your certifying board and request that the verifications be submitted electronically to the Georgia Board of Nursing at [PLB-Healthcare3@sos.ga.gov](mailto:PLB-Healthcare3@sos.ga.gov).

**Board Disciplinary Actions/Legal Convictions** – Answer all of these questions or the application will be returned. If you responded “yes”, to either question, follow the instructions on the application. Be sure to include your personal detailed statement regarding the incident with your application and enclose the requested supporting documents with the application.

## APPLICATION PROCESSING INFORMATION

- A. To ensure fairness to all applicants, all applications are reviewed in the order received. If all the necessary documentation is present and the appropriate verifications of licensure have been received, the authorization is approved and issued following that review. If the application documentation is incomplete, a letter is sent to the applicant notifying them of the deficiencies. If your application for authorization is approved, the authorization is issued. It will be sent directly to the official mailing address provided by the licensee. You can track your application status at [www.sos.ga.gov/plb/m](http://www.sos.ga.gov/plb/m).
- B. An application is valid for one year from the date of submission. If APRN authorization has not been approved within the year, the application will be rendered expired. If the applicant wishes to pursue authorization, a new application, fee, and supporting documents must be resubmitted.
- C. Upon receipt of the pocket card, the applicant should verify the accuracy of all information. Notify the Board in writing immediately if there are any typographical errors.

## LEGAL REQUIREMENTS FOR ADVANCED PRACTICE REGISTERED NURSE AUTHORIZATION

- A. Active Georgia registered nurse license.
- B. Master's or higher education in area of specialty.
- C. Active national certification in area of specialty.
- D. If applicable, verification that applicant has met active practice requirement as detailed in board rules.
- E. Before an individual can practice as a certified nurse practitioner, certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, psychiatric/mental health, or clinical nurse specialist they must possess an APRN authorization from the State of Georgia. A Georgia registered nurse license with an advanced practice specialty designation on its face demonstrates advanced practice authorization. The licensee is responsible for maintaining current national certification.
- F. Upon receipt of your original pocket card, note the expiration date of both the registered nurse license and the advanced practice authorization. The Board will not mail renewal notices. It is your responsibility to renew your license on or prior to your expiration date. Paper renewals will only be available by request. If you need a paper renewal, you may contact the Georgia Board of Nursing at (478) 207-2440.





**OFFICIAL TRANSCRIPT**

**17. Official Transcript:** An official sealed transcript verifying your graduation date and degree conferred from an approved nursing program **must be submitted with this application.**

Have you included an official sealed transcript?                     **No**     **Yes**

Advanced Pathophysiology course number \_\_\_\_\_

Advanced Pharmacology course number \_\_\_\_\_

Advanced Health Assessment course number \_\_\_\_\_

**PREVIOUS LICENSURE INFORMATION**

**18. Have you ever applied for authorization in Georgia?**

- No**
- Yes**

If yes, when? \_\_\_\_\_ Under what Name? \_\_\_\_\_

**State of original APRN licensure in the United States or its territories. Identify the name of the APRN examination taken and date the examination was passed leading to licensure:**

State: \_\_\_\_\_ Year Issued: \_\_\_\_\_

APRN National Certification Exam Taken: \_\_\_\_\_ Date Passed: \_\_\_\_\_

List all states in which you have ever been licensed as an APRN: (Use additional paper if necessary.)

<b>State:</b> _____	<b>License Number:</b> _____	<b>Expiration Date:</b> _____
<b>State:</b> _____	<b>License Number:</b> _____	<b>Expiration Date:</b> _____
<b>State:</b> _____	<b>License Number:</b> _____	<b>Expiration Date:</b> _____
<b>State:</b> _____	<b>License Number:</b> _____	<b>Expiration Date:</b> _____
<b>State:</b> _____	<b>License Number:</b> _____	<b>Expiration Date:</b> _____

## EMPLOYMENT HISTORY

**19. Employment History:** Have you practiced as an APRN in the four (4) years immediately preceding the date of this application?

No Yes

Have you practiced as a clinical nurse specialist in Georgia prior to January 1, 2012?

No Yes

(Any applicant that does not meet these practice requirements **MUST** complete a Georgia Board of Nursing Approved Re-entry Program.)

**The Georgia Board of Nursing makes licensure decisions based on the information submitted on this application. Any applicant practicing as an APRN without authorization will be subject to Board review. The Board requires a personal, detailed notarized letter of explanation and detailed employment information from the employer's HR department for any APRN practice in Georgia without valid authorization. A verification of employment form must be provided for each employment within the last 4 years listed on the grid below.**

Employer's Name/Address	Actual Workplace Location Facility Name/City/State	Position Title	Is APRN Authorization required?	Dates From - To (mo/yr)-(mo/yr)
<b>A.</b>				
<b>B.</b>				
<b>C.</b>				

**PREVIOUS DISCIPLINARY AND CRIMINAL CONVICTION INFORMATION**

**20. Board Disciplinary Actions/Legal Convictions:** (Answer **ALL** Questions)

- A.** Have you ever been arrested or convicted of a felony, misdemeanor (other than a minor traffic violation), crime involving moral turpitude, or a crime violating federal or state law relating to controlled substances or dangerous drugs? (DWI and DUI are not minor traffic violations.) For purposes of this question, a “conviction” includes a finding of verdict of guilty, plea of guilty, a plea of nolo contendere, or first offender treatment, and also includes adjudication of guilt or sentence withheld or not entered on the charge (s). **NOTE: The answer to this question is “YES” if an arrest or conviction has been pardoned, expunged, dismissed or deferred, you pled & completed probation under First offender and/or your civil rights have been restored and/or you have received legal advice that the offense will not appear on your criminal record.**

No      Yes

If “**yes**”, have you included a **certified copy** of the court records and final disposition in a **sealed envelope from the court** with your application? **In the event the file no longer exists, you must submit documentation from the court stating that fact.**

Have you included a **personal, detailed letter** explaining each incident?  No      Yes

- B.** Have you undergone treatment for drug or alcohol abuse within the last five years?  No      Yes

If “yes,” please include all information relevant to your diagnosis, prognosis, treatment plan, practice recommendations and discharge summary. Also include a personal letter of explanation regarding each incident.

- C.** Has any licensing board or agency in Georgia or any other state ever:

- |   |   |
|---|---|
| (a) Denied your application, for licensure, renewal or reinstatement?     | <input type="checkbox"/> No      Yes <input type="checkbox"/> |
| (b) Revoked, suspended, restricted, sanctioned, or probated your license? | <input type="checkbox"/> No      Yes <input type="checkbox"/> |
| (c) Requested or accepted surrender of your license?                      | <input type="checkbox"/> No      Yes <input type="checkbox"/> |
| (d) Reprimanded, fined or disciplined you?                                | <input type="checkbox"/> No      Yes <input type="checkbox"/> |

If “**yes**”, have you included a **certified copy** of that board or agency’s action against your license with relevant supporting documents in a **sealed envelope from the board or agency** with your application?

No      Yes

Have you included a personal, **detailed letter** explaining each incident?  No      Yes

Provide the name of the agency or board in the space provided.

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Name of agency or board

**NOTARIZED SIGNATURE BY APPLICANT**

21. I, \_\_\_\_\_, certify that I am the person described and identified in this application. I have answered all the questions truthfully and completely, and any documents that I have provided in support of my application are, to the best of my knowledge, true and accurate.

I hereby authorize the Georgia Board of Nursing to perform and to receive any criminal history record pertaining to me, which may be in the files of any state or local criminal justice agency in Georgia or any other State or Territory. The Georgia Board of Nursing is hereby authorized to request any information necessary to process my application.

Under penalties of perjury, I understand that any false or misleading information in, or in connection with my application, may be cause for denial or revocation of licensure.

Applicant signature and notarization should occur on the same date.

\_\_\_\_\_  
Date Signed

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

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_.

\_\_\_\_\_  
(Signature of Notary Public)

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

**Complete the required portion and send the attached Verification of Certification to your certifying board and request it send the Verification of Certification to you in a SEALED ENVELOPE. Include the sealed envelope with your application.**

**Have you...**

- Answered each question?
- Included your official transcript with course description from your school?
- Requested Verification of National Certification from the appropriate certification board be submitted to PLB-Healthcare3@sos.ga.gov.

<b>Mail to:</b>	<b>Georgia Board of Nursing 237 Coliseum Drive Macon, Georgia 31217</b>
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**GEORGIA BOARD OF NURSING**

237 Coliseum Drive  
Macon, Georgia 31217-3858  
(478) 207-2440

**VERIFICATION OF NATIONAL CERTIFICATION AS A  
NURSE-MIDWIFE, NURSE PRACTITIONER, NURSE ANESTHETIST, CLINICAL NURSE SPECIALIST OR  
CLINICAL NURSE SPECIALIST-PSYCHIATRIC/MENTAL HEALTH**

**APPLICANT:** Complete this section and forward to your national certification board. Inquire if there is a fee for completing this form and mail fee with this form to your respective national certification board. National certifying organizations must be contacted by the applicant to request verifications be submitted electronically to the Georgia Board of Nursing at [PLB-Healthcare3@sos.ga.gov](mailto:PLB-Healthcare3@sos.ga.gov).

Name \_\_\_\_\_

**Last First Middle Maiden**

Address \_\_\_\_\_

**Street City State Zip**

Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_

Name of Advanced Practice Nursing Education Program \_\_\_\_\_

Location (city/state) \_\_\_\_\_

Date of Completion/Graduation \_\_\_\_\_

National Certification Board \_\_\_\_\_

Type of Certification \_\_\_\_\_

Certification Number (if applicable) \_\_\_\_\_

I hereby authorize the designated national certification board to furnish the information requested to the Georgia Board of Nursing.

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

**FOR CERTIFICATION BOARD ONLY**

This is to certify that the above named was issued certification \_\_\_\_\_ number \_\_\_\_\_ to practice

as a \_\_\_\_\_ on \_\_\_\_\_  
**(State Type of Certification) (Initial Certification Date)**

Initially Certified by: \_\_\_\_\_ Examination \_\_\_\_\_ Other Evaluation (Please Explain)

Certificate/Recertification Expires: \_\_\_\_\_

**BOARD SEAL**

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

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Board**

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

\_\_\_\_\_  
**Telephone #**

## DOCUMENTATION TO DETERMINE QUALIFIED ALIEN STATUS

**APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS. RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION.**

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

Issued August 1, 2011 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]

\_\_\_\_\_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)]

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature) (Date)



**OFFICE OF SECRETARY OF STATE  
PROFESSIONAL LICENSING BOARDS DIVISION  
GEORGIA BOARD OF NURSING  
237 Coliseum Drive  
Macon, Georgia 31217  
(478) 207-2440**

**CONSENT FORM**

I hereby authorize the Georgia Board of Nursing ("Board") to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

\_\_\_\_\_  
Full Name (Print)

\_\_\_\_\_  
Physical Address (P.O. Boxes NOT Accepted)

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Race

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

**One of the following must be checked:**

This authorization is valid for 90/180/\_\_\_ (circle one) days from date of signature.

I, \_\_\_\_\_ give consent to the Board to perform periodic criminal history background checks for the duration of my licensure with this state.

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

\_\_\_\_\_  
Date

Special licensure provisions (check if applicable):

\_\_\_\_ Working with mentally disabled

\_\_\_\_ Working with elder care

\_\_\_\_ Working with children

**GEORGIA BOARD OF NURSING**

237 Coliseum Drive  
Macon, Georgia 31217

**VERIFICATION OF EMPLOYMENT FOR ADVANCED PRACTICE AUTHORIZATION APPLICANTS**

**Instructions:**

1. Applicant: Complete Section I and sign.
2. Submit this form to your employer to verify paid registered nursing practice. Ask the employer to complete the form and place it in a sealed envelope by them for you to be submitted with your application.

**Section I (To be completed by applicant)**

\*The name and address of your employer on this form must match the name and address you listed under "Employment History" on the application.

Printed Name of Applicant: \_\_\_\_\_  
Last First Middle Maiden

Applicants Address: \_\_\_\_\_  
Street City State Zip Code

**RELEASE:** I do hereby consent to and authorize the release of any and all records and information concerning my employment to the Georgia Board of Registered Nursing. I understand this information is required as part of the application for licensure process.

Signature of Applicant \_\_\_\_\_ Applicant Phone Number (s) \_\_\_\_\_

**APPLICANT – DO NOT WRITE BELOW THIS LINE:**

**Section II (To be completed by person verifying employment):**

**Instructions:**

1. Complete Section II of this form.
2. You must respond to all questions or this form will not be accepted by the Board office.
3. Employment must have been for compensation.
4. **Each title held with one employer requires a separate verification form completed.**

1. Name of Facility/Business/Employer: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_  
Is this a federal agency of the United States Government?  No  Yes

2. Physical Address of Location: \_\_\_\_\_  
City State Zip

3. Employee's Position/Title: \_\_\_\_\_

4. Is an RN license necessary for employment in this position?  No  Yes

5. Is APRN authorization required for employment?  No  Yes

6. Identify the actual physical location where the employee practiced to include facility name, city/state if different than # 2 above or indicate same as above:  
\_\_\_\_\_

7. Employment Dates: From: \_\_\_\_\_ (mo/yr) - To: \_\_\_\_\_ (mo/yr)  
Were there any periods of extended absence during employment?  No  Yes If "yes" please provide dates \_\_\_\_\_

**LIST BELOW THE NUMBER OF HOURS WORKED PER YEAR AND Job Description: List below the number of hours worked per year and duties:**

Year	Hours worked	Job Description

8. Printed name and title of person verifying employment: \_\_\_\_\_

9. I hereby certify that I am a custodian of records at \_\_\_\_\_ and the information submitted on this form is a true and correct representation of this applicant's file with our institution.

10. Signature of employer representative completing this form: \_\_\_\_\_ Date \_\_\_\_\_

**Employer Representative's Signature Must Be Notarized**

Sworn to and subscribed before me this

\_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
**(Notary Public)**

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

(Notary Seal)

**Affidavit Regarding Citizenship**

Please submit this document along with a copy of your secure and verifiable document to the Board office as indicated on the application.

Print Name: \_\_\_\_\_

**APPLICANT AFFIDAVIT:**

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Board for which I am applying for licensure and I agree to abide by these laws and rules.

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, administered by the Professional Licensing Boards Division, the undersigned applicant also verifies one of the following with respect to his/her application for a public benefit (check one):

- 1) \_\_\_\_\_ I am a United States citizen. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver’s license, passport, or document as indicated on the Board’s website.**
- 2) \_\_\_\_\_ I am not a United States citizen, but I am either a legal permanent resident of the United States or 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. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.**

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.

In making the above representations 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. I also understand that any failure to make full and accurate disclosures may result in disciplinary action by the Board for which I am applying for licensure.

Executed in \_\_\_\_\_ (city), \_\_\_\_\_(state).

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

\_\_\_\_\_  
Printed Name of Applicant

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE

\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC My Commission Expires: