GEORGIA Center for Obstetrics Re-entry Program

Department of Obstetrics & Gynecology

AUGUSTA UNIVERSITY
MEDICAL COLLEGE OF GEORGIA
Georgia Center for Obstetrics Re-Entry Program

APPLICANT INFORMATION							
Last Name		First		MI		Date	
Street Address				Apartment/Unit #			
City		State		ZIP			
Phone		E-mail Address					
Date(s) Available				Gender			
GA Medical License Number		DEA Number		ABOG Number			

Are you a citizen of the United States?	YES ☐	NO ☐	City/State/Country of Birth?	
Have you ever been convicted of a crime, other than a minor traffic violation?	YES ☐	NO ☐	If yes, explain	
Have you ever been involved in any professional liability suits (including cases brought, pending, settled, or decided)?	YES ☐	NO ☐	If yes, explain	

Have you ever been, or currently in the process of being , denied, revoked, suspended, reduced, limited, placed on probation, not renewed, voluntarily or involuntarily relinquished, or have you ever withdrawn, or failed to proceed with an application in any of the following? (Use additional pages if needed for explanations)

Medical license in any state	YES ☐	NO ☐	If yes, explain	
Other professional registration or license	YES ☐	NO ☐	If yes, explain	
DEA/controlled substance registration	YES ☐	NO ☐	If yes, explain	
Membership to any hospital medical staff	YES ☐	NO ☐	If yes, explain	
Clinical privileges	YES ☐	NO ☐	If yes, explain	
Professional liability insurance	YES ☐	NO ☐	If yes, explain	

Any other type of professional sanction	YES ☐	NO ☐	If yes, explain	

EDUCATION								
Undergraduate Education					Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree	
Medical Education					Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree	
Other					Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree	

GRADUATE MEDICAL EDUCATION			
Internship		Start	End
Address			
Residency		Start	End
Address			
Fellowship		Start	End
Address			

PREVIOUS EMPLOYMENT (MOST RECENT FIRST; USE ADDITIONAL PAGES IF NEEDED)					
Institution				Phone	
Address				Supervisor	
Job Title					
Responsibilities					
From		To		Reason for Leaving	

Comments					
Institution		Phone			
Address		Supervisor			
Job Title					
Responsibilities					
From		To		Reason for Leaving	
Comments					
Institution		Phone			
Address		Supervisor			
Job Title					
Responsibilities					
From		To		Reason for Leaving	
Comments					

MILITARY SERVICE					
Branch		From		To	
Rank at Discharge		Type of Discharge			
If other than honorable, explain					

Please write a **brief** statement regarding your **needs** for re-entry and **intentions** for medical practice following completion of the program (including planned venue and location of practice).

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. If this application leads to my participation in the re-entry program, I understand that false or misleading information in my application or interview may result in my dismissal from the program.

I understand that if I am **dismissed from the program** for any reason prior to completion or **fail to re-enter the practice of obstetrics in the State of Georgia**, I will be responsible for the fees of participation in the program, based on length of time in the program, equaling up to **fifty-thousand dollars**. These fees are waived (covered in the budget of the State of Georgia as voted on by the Georgia Assembly and signed by the Governor) for individuals re-entering practice to enter the Georgia workforce.

By signing this application for participation in the GA CORP program, you are certifying your intent to practice obstetrics in the State of Georgia upon completion.

Signature		Date	

GA Corp is **not affiliated** with the **Composite Board of Medical Examiners for Georgia nor the American Board of Obstetrics and Gynecology**. This program is **not sanctioned by the American College (Congress) of Obstetrics and Gynecology** but is recognized as important for the demands of a dwindling workforce in OB/GYN. By completing the re-entry program, you will be given a summative report of your clinical skills, milestones met, procedural volume, and a certificate of completion. Applicants should very clearly understand the needs of any regulatory agency as to whether the completion of a re-entry program will be recognized for attainment of any deficiencies required for practice or credentialing. **The program will not be held responsible for failure of the participants to maintain licensure, board-certification, or in circumstances of malpractice.**

Please email (chray@augusta.edu) or fax (706-721-6211) completed application to Chadburn Ray, MD, FACOG. For more information on the GA Center for Obstetrics Re-entry Program, please call 706-721-2542.

For Program Use Only:

Application Received (Date/Signature): _____

Credentialing Information Sent to Applicant ☐ Date Received from Applicant: _____

Signature of Program Director and Date of Approval: _____