Dear Applicant:

Enclosed are information and application materials for the Georgia Physician Loan Repayment Program (GPLRP) administered by the Georgia Board of Health Care Workforce (GBHCW or Board).

The purpose of this program is to grant service cancelable loans of up to $25,000.00 per year to physicians to repay their outstanding medical education debt on the condition that the physician practice full-time in an underserved rural area in Georgia. A participant in the program must practice for a minimum of 2 years in a targeted rural area.

A participant may elect to re-apply for additional funding awarded on an annual basis for 2 years for a maximum of 4 years funding with approval of the Georgia Board of Health Care Workforce. The targeted underserved rural areas under this program are federally designated Health Professional Shortage Areas (HPSA) and are subject to change. The HPSA status of the practice location listed on the application will be evaluated prior to each award cycle. Also, a practice site must be located in a Georgia county with a population of 50,000 or less according to the most recent U.S. Decennial Census.

The GPLRP requires physicians to practice in the following specialties: Family Medicine (or Osteopathic General Practice), Internal Medicine, Pediatrics, Obstetrics/Gynecology, Geriatrics or Psychiatry.

To apply for the GPLRP, complete the enclosed Application, Lender Disclosure Form(s), and forward the Practice Site Assessment to the appropriate individual at your practice site to complete and return to the GBHCW.

All application materials must be received by May 1st. Applications will be presented to the Board at the next meeting after the due date.

Please contact our office at (404) 232-7972 or at gbhcw@dch.ga.gov if you have questions.

Sincerely,

LaSharn Hughes, MBA
Executive Director

Enclosures
GEORGIA PHYSICIAN LOAN REPAYMENT PROGRAM

PURPOSE OF THE PROGRAM

The Georgia Physician Loan Repayment Program (GPLRP) is a service cancelable loan for medical education debt repayment program funded by the State of Georgia and a grant from the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA).

The purpose of the GPLRP is to:

• Build viable practices in Georgia’s medically underserved areas;

• Encourage economic growth in Primary Medical Care and Mental Health Professional Shortage Areas;

• Improve healthcare delivery by increasing access to health care and minimizing disparities for rural Georgians.

Eligible counties must have populations of 50,000 or fewer persons according to the most recent United States Census and be designated as a Primary Medical Care or Mental Health Professional Shortage Area (HPSA) by the federal government.

In return for practicing in an eligible rural Georgia county, physicians, especially those practicing in Primary Care*, will receive a payment of $50,000 over two years and can reapply for 2 additional, one year obligations in return for a maximum of $25,000 each.

Funds provided through this program are to be used for the repayment of existing medical education loan debt. Qualified medical education loans are defined below in the Application Requirements section. To be considered for an award, applicants must document all outstanding medical education loan debt.

ELIGIBLE STUDENT LOANS

Qualifying educational loans are Government and commercial loans for actual costs paid for tuition and reasonable educational and living expenses related to the education of the applicant.

If the applicant has a consolidated/refinanced loan that is made up entirely of qualifying education loans of the applicant, the consolidated/refinanced loan is eligible for repayment. If the applicant has consolidated otherwise qualifying educational loans with any non-qualifying debt, no portion of the consolidated/refinanced loan will be eligible for repayment.

Individuals who have Primary Care Loans through the Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions are NOT eligible to participate in the GPLRP.
REQUIREMENTS AND CONTRACTUAL OBLIGATIONS

GPLRP participants must practice their profession for an initial contract period of two years at a site approved by the Board and that is in compliance with Federal Loan Repayment Program requirements. Approved sites must be located in a federally recognized Primary Medical Care Health Professional Shortage Area (HPSA) or Mental Health Professional Shortage Area (MHPSA) for psychiatrists, which are also in a Georgia county with a population of 50,000 or less according to the 2010 U.S. Decennial Census. Award recipients may be eligible for two contract renewals of one year each.

The GPLRP requires practice sites also be a public or nonprofit facility. Public facilities would include those owned and operated by the Georgia Department of Public Health, Georgia Department of Behavioral Health and Developmental Disabilities, Georgia Department of Corrections, or Georgia Department of Juvenile Justice or Federally Qualified Health Centers (FQHCs).

Physicians must practice their specialty full-time, defined as 40 hours per week of patient care, with no more than 8 of those hours per week devoted to practice-related administrative activities, at the practice entity named in the application.

For all physicians, 40 hours per week may be compressed into no less than 4 days per week with no more than 12 hours of work to be performed in any 24-hour period. Hours worked over 40 hours per week will not be applied to any other work week. Participants must work at least 45 weeks per service year providing primary health services. No more than 7 weeks (35 workdays) per year can be spent away from the practice for vacation, holidays, continuing professional education, illness, or any other reason. Absences greater than 7 weeks in a GPLRP service year will extend the service commitment end date.

At least 32 hours per week must be spent providing direct patient care. These services must be conducted during normally scheduled clinic hours in the ambulatory care setting office(s). The remaining hours must be spent providing inpatient care to patients of the approved site and/or performing practice-related administrative activities.

Research and teaching are not considered to be “clinical practice” and time spent “on-call” is not considered part of full-time practice. An exception to these rules is allowed for providers of obstetrical care.

For obstetrical care providers (OB/GYNs or FPs who practice obstetrics on a regular basis), the majority of full-time service (not less than 21 hours per week) is to be devoted to direct patient care in an approved ambulatory care practice site during normal scheduled office hours. The remaining hours can be spent providing inpatient care to patients of the approved site and/or on practice related administrative duties. Time spent on administrative duties cannot exceed 8 hours per week. Time spent “on-call” is not considered part of full-time practice.

The funds that the physician may receive from this program are in addition to any other salary, benefits or other compensation the physician receives as part of a practice and/or employment arrangement provided there is no duplication of benefits.

Recipients of the GPLRP funding will be responsible for submitting a mid-term status report to allow the Board to monitor compliance of program’s requirements.
**APPLICANT ELIGIBILITY**

Eligible Applicants must:

- be a citizen of the United States of America or a U.S. National;
- be licensed to practice medicine within the State of Georgia at the time the application is made;
- be a graduate of a graduate medical education program located in the United States which has received accreditation or provisional accreditation by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association designed to qualify the graduate for licensure by the Georgia Composite Medical Board;
- be a practitioner in one of these approved specialties: *Family Medicine (and osteopathic general practice), Internal Medicine, Pediatrics, Obstetrics/Gynecology, Geriatrics, Psychiatry*.
- serve patients regardless of their ability to pay and make use of a sliding fee scale for payment of services; also accept Medicare, Medicaid and PeachCare and prominently display a sign stating all provisions as provided above.

**Applicants are ineligible if they:**

- are a GBHCW Scholarship recipient currently servicing a State of Georgia obligation,
- have other current service obligations to the Federal Government (e.g., National Health Service Corps, Military Service Obligations) or a State or other entity, prior to the beginning of this contract nor has defaulted on any previous service obligations to the Federal Government or State of Georgia. Not to include individuals in the Reserves of the U.S. Armed Forces or National Guard. However, the GPLRP service obligation will be extended to compensate for the break in “full-time” service if participation in the reserves or a combination with other absences from the service site exceeds 35 workdays/service year.
- have a judgment or lien against property for debt to the United States.
- have defaulted on any FEDERAL payment obligations (e.g., Health Education Assistance Loans, Federal income tax liabilities, Federal Housing Authority loans, etc.) even if the creditor now considers them to be in good standing;

**PROGRAM PROVISIONS**

**Waiver**

A participant may request a waiver of the GPLRP obligation. A waiver is a permanent status. In order to qualify for a waiver of the GPLRP service obligation, a participant must document a medical condition or a personal situation that makes compliance with the obligation permanently “impossible” or an “extreme hardship” such that enforcement would be against equity and good conscience. An example would be an illness so debilitating that the participant can no longer practice his/her profession.
Suspension

Participants may request a suspension of their GPLRP obligation. A Suspension may be granted for up to 1 year. In order to qualify for a suspension, the participant must document a medical condition or personal situation that makes compliance with the obligation temporarily “impossible” or an “extreme hardship” such that enforcement would be against equity and good conscience. Examples would be the terminal illness of an immediate family member for whom the participant is caretaker or extended maternity leave due to medical complications.

Default

Participants who fail to begin or complete their GPLRP service obligation or otherwise breach the terms and conditions of the obligation are in default of their contracts and are subject to the financial consequences outlined in their contracts.

Cancellation

The only permissible basis for canceling a Georgia Physician Loan Repayment Program contract is the death of the GPLRP participant.

Breach of Contract Penalty

A participant who breaches their obligation will be subjected to paying an amount equal to the total of the amount paid by the GPLRP to, or on behalf of, the participant for loan repayments for any period of obligated service not served; and an amount equal to the number of months of obligated service not completed multiplied by $7,500; interest on the above amounts at the maximum legal prevailing rate, as determined by the treasurer of the United States, from the date of breach, except that the amount to recover will not be less than $31,000; and the total amount owed is due within one year of the breach.

Penalty = [Total GPLRP Payout + (Remaining Months’ of Service *$7500)]

Facts to Remember

Practice entities must be either a public or nonprofit facility and be located within a designated Health Professional Shortage Area (HPSA) and in a county of 50,000 or less population

As of January 1, 2004, funds disbursed for the Georgia Physician Loan Repayment Program are exempt from gross income and employment taxes. These funds are also excluded from being taken into account as wages in determining benefits under the Social Security Act.

While the GBHCW understands the vested interest of multiple partners in your obtaining financial assistance, they are not obligated in any way to statements of fact not incorporated as a part of this document or other documents prepared by the authority of the GBHCW. Representations as to regulations, the likelihood of funding, amount of funding, manner, and time schedule for funding may be unreliable if not obtained from the GBHCW. Program eligibility is solely determined by the GBHCW.
Georgia Board of Health Care Workforce

Georgia Physician Loan Repayment Program Application Cover Sheet

Please place this cover sheet on top of your application when it is returned. Please initial by each item signifying that it is enclosed. All materials must be returned under this cover sheet in one packet and postmarked by May 1st.

Applicants Name _____________________________________________________

☐ Materials Enclosed With This Packet:

_____ GPRLP Application (pages 6-10), with proper notary signature

_____ Authorization and Release Form (page 12), with proper notary signature

_____ O.C.G.A. 50-36-1(e)(2) Affidavit (page 13), with proper notary signature

_____ Copy of at least one secure and verifiable document (list provided on pages 14-15)

_____ Practice Site Application (pages 18-20), completed by employer and with proper notary signature

_____ Copy of ALL contracts between applicant and employer(s)

_____ Copy of Most Recent Federal Tax Return AND W-2’s showing total compensation*

*If this is not available due to being at current practice less than 1 year, pay stubs must be provided for all months worked AND a letter from contracting agency (if applicable) outlining any incentive pay

☐ Materials I Mailed Directly To My Lender (Do Not Mail Original Lender Disclosure to GBHCW):

_____ Lender Disclosure form(s) (page 11) sent to Lender(s) Date sent to Lenders: ____________

By signing below, I am verifying that all documents listed above are enclosed and complete. I understand that it is my responsibility to ensure my lenders return the disclosures in the proper timeframe. I understand that any disclosures not postmarked by May 1st may not be considered.

Applicant Signature ________________________________________  Date ________________

Mail your completed application to:

Georgia Board of Health Care Workforce
Attn: Georgia Physician Loan Repayment Program
2 Peachtree Street, NW, 6th Floor
Atlanta, Georgia 30303-3141
I. Personal Data

Full Legal Name:_____________________________________________________________

Address: ____________________________________________________________________

City:____________________________ County:____________________________________

State:________________________ Zip Code:______________________________________

Primary Phone:________________________ Secondary Phone:________________________

Social Security Number:______________ Email: ________________________________

II. Specialty Practicing

_____ Family Medicine     _____ Family Medicine with OB     _____ General Internal Medicine

_____ General Pediatrics     _____ Obstetrics/Gynecology     _____ Geriatrics

_____ Psychiatry

Do you work as a/an: Hospitalist      Yes     No       Emergency Room Doctor    Yes      No

(Circle One) (Circle One)

III. Medical Education

Medical School:___________________________________ Graduation Date:_____________

City:__________________________ State:_________________ Degree:     MD       DO

Residency Hospital:_________________________________ Graduation Date:____________

City:__________________________ State: __________________

Residency Hospital:_________________________________ Graduation Date: ___________

City:__________________________ State: __________________

Board Certified:   (Circle One) Yes     No   Board Eligible:   (Circle One) Yes     No

Georgia Medical License Number: ___________

Medicaid Provider Number(s): ____________
IV. Practice Information

Applicant agrees to provide full time, primary care services in _________ for one year at:

Practice Site Name: ____________________________________________________________

Address: ____________________________________________________________________

City: __________________ County: __________________________ Zip Code: ___________

Website: _____________________________________________________________________

Type of Practice: (Circle One)  Solo [no income guarantee]  Solo [contracted income guarantee]  Group

Hospital  Other  (Please Specify)___________________________________________________

Number of clinical hours per week at this location: _________________________________

Beginning date of practice: ________________ Total Annual Compensation:______________

Are you receiving loan repayment through this employer? (Circle One)  Yes  No

If yes, how much and what are the terms? ________________________________________

______________________________________________________________________________

Additional Practice Site Information (if applicable):

Practice Site Name: ____________________________________________________________

Address: ____________________________________________________________________

City: __________________ County: __________________________ Zip Code: ___________

Website: _____________________________________________________________________

Type of Practice: (Circle One)  Solo [no income guarantee]  Solo [contracted income guarantee]  Group

Hospital  Other  (Please Specify)___________________________________________________

Number of clinical hours per week at this location: _________________________________

Beginning date of practice: ________________ Total Annual Compensation:______________

Are you receiving loan repayment through this employer? (Circle One)  Yes  No

If yes, how much and what are the terms? ________________________________________

______________________________________________________________________________

*Include a copy of all contracts between yourself and your practice/employer(s)
V. Medical Education Debt

Estimate of total outstanding MEDICAL educational debt from all loan holders: $_________

Request a submission of the attached Lender Disclosure Form from each loan holder. Attach a current statement for each loan listed. Loan statements must contain applicant’s name, account number, the principal, and pay off balance.

1. Loan Holder:______________________________________________________________
   Loan Holder Address: _________________________________________________________
   City:__________________ State:____________________________ Zip Code: ___________
   Account Number:_________________________________________ Loan Balance: $_________

2. Loan Holder:______________________________________________________________
   Loan Holder Address: _________________________________________________________
   City:__________________ State:____________________________ Zip Code: ___________
   Account Number:_________________________________________ Loan Balance: $_________

3. Loan Holder:______________________________________________________________
   Loan Holder Address: _________________________________________________________
   City:__________________ State:____________________________ Zip Code: ___________
   Account Number:_________________________________________ Loan Balance: $_________

4. Loan Holder:______________________________________________________________
   Loan Holder Address: _________________________________________________________
   City:__________________ State:____________________________ Zip Code: ___________
   Account Number:_________________________________________ Loan Balance: $_________

5. Loan Holder:______________________________________________________________
   Loan Holder Address: _________________________________________________________
   City:__________________ State:____________________________ Zip Code: ___________
   Account Number:_________________________________________ Loan Balance: $_________
VI. Certification

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I hereby consent fully to verification of any and all information included in this application. I understand that any willfully false representation of information is sufficient cause for rejection of this application. I have fully disclosed all outstanding loan debt and am not currently in default of any service or loan obligation.

_____________________________________                                       _______________
Applicant’s Signature (Full Legal Name)                                      Date

Official Notary:

I HEREBY CERTIFY that on this day, personally appeared in front of me, an officer duly authorized to administer oaths and take acknowledgements, ______________________ (applicant’s name), to me known to be the person described herein and who executed the forgoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at the City of ______________, County of __________ and
State of ______________________, this ______ day of __________, 20____.

____________________________________________________________
Notary Public (Full Legal Signature)

Affix Seal                                                   My Commission expires: __________________
Georgia Physician Loan Repayment Program

Outstanding Medical Education Loan Debt Information

--------LENDER DISCLOSURE--------

**Applicant:** This form must be sent to each lending institution or agency for which you are seeking loan repayment. Please complete the red areas prior to sending to the lender. The lending institution must forward the completed form to our office no later than June 1st.

**Lender:** If the named individual’s application is approved, the information requested below will be used to arrange third party pre-payment of a portion or all of the applicant’s debt.

**Applicant’s Name as it Appears on Loan:** ______________________________________________

**Original Lending Institution, Federal or State Program, Please Provide:**

<table>
<thead>
<tr>
<th>Full Name of Institution or Program</th>
<th>Contact Person</th>
<th>Telephone Number</th>
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<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tr>
<th>Loan ID Number</th>
<th>Original Loan Amount</th>
<th>Date of Original Loan</th>
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<tr>
<th>Grace Period/Forbearance Dates</th>
<th>Current Balance</th>
<th>Date of Balance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
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</table>

<table>
<thead>
<tr>
<th>Interest Rate</th>
<th>Simple or Compound</th>
</tr>
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<tbody>
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</table>

If interest rate is variable, explain terms: __________________________________________________________

**Purpose of loan as indicated on original loan application:** __________________________________________

**Certification by Applicant Borrower:**

I hereby authorize the government or financial Institution named above to release this information to the Georgia Board of Health Care Workforce for the purpose of repayment of outstanding medical education debt through the Georgia Physician Loan Repayment Program.

I also certify the accuracy of the enclosed information and apply to enter into an agreement with the GEORGIA BOARD OF HEALTH CARE WORKFORCE - GEORGIA PHYSICIAN LOAN REPAYMENT PROGRAM of all or the appropriate portion of the education loan listed above, incurred solely for the cost of medical education, including reasonable living expense at a school of medicine.

**Full Legal Signature:** ___________________________________________ Date: ________________

**Certification by Authorized Agency of Lending Institution:**

The undersigned states that, to the best of his or her knowledge, the loan identified above is a bona fide, legally enforceable, commercial, state or government educational loan, made for the purpose of meeting the borrower’s costs of attaining the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.).

**Print/Type Name of Authorized Agent**

**Official Signature:** __________________________________________________________________________

**Lender Organization’s Federal Employer Identification Number:** ____________________________

Return to: Georgia Board of Health Care Workforce, 2 Peachtree Street, NW, 6th Floor, Atlanta, GA 30303-3141
GEORGIA BOARD OF HEALTH CARE WORKFORCE
AUTHORIZATION and RELEASE FORM
for the Georgia Physician Loan Repayment Program

FULL LEGAL NAME OF APPLICANT: __________________________________________________________

TO WHOM IT MAY CONCERN:
I, ________________________________________, have filed an application with the Georgia Board of Health Care Workforce’s
Applicant’s Full Legal Name
Georgia Physician Loan Repayment Program to repay the cost of my tuition and other expenses while obtaining my medical
education and training. I recognize that it is the responsibility of the members of said Board to determine that only those qualified
persons who have entered into a contract with an eligible practice entity, submitted all required application forms and documentation
and disclosed all medical education debts and obligations, are eligible for loan repayment. To this end, and for the entire contract
period, I hereby authorize and request any college or school official, lending institution or organization and any other person or
official of any firm, association or corporation, to answer any inquiries, questions, interrogatories, or furnish any information
whatsoever concerning the undersigned on forms or requests which may be submitted to them by the Georgia Board of Health Care
Workforce or its authorized representative, and to appear before said Board, or its authorized representative, and to give full and
complete testimony concerning the undersigned, including any information furnished by the undersigned. I hereby relinquish any
and all rights to said reports, evaluations, consultations, letters of recommendation or any other information or material incident
in any way to authorized reviews by Georgia Board of Health Care Workforce, or its authorized representative, and fully understand
that I shall not be entitled to have disclosed to me the contents of any of the foregoing.
I hereby release and exonerate all such persons authorized by the Georgia Board of Health Care Workforce, who shall comply in
good faith with this authorization and request from any and all liability of every nature and kind whatsoever growing out of or in any
way pertaining to the furnishing of such information or inspection of any document, record and other information or any
investigation by said Georgia Board of Health Care Workforce.
Further, the undersigned hereby waives absolutely any right which he/she may have under the laws of Georgia governing
confidential or privileged communications, as codified in the Official Code of Georgia Annotated, as now or hereafter amended.

IN WITNESS WHEREOF, I have set my hand and seal this ________day of ___________________, 20______.

_______________________________________________
Applicant’s Full Legal Signature

STATE OF ____________________________  COUNTY OF ____________________________

OFFICIAL NOTARY:
I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take
acknowledgments, _______________________________________________________________,
Applicant’s Full Legal Name
to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me
that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at City of ____________________________, County of ____________________________,
and State of ____________________________, this _______ day of ____________________________, 20______.

(Place Seal Imprint Here)  ________________________________
Legal Signature, Notary Public

My Commission Expires: ____________________________  Revised: April 2020
O.C.G.A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for the Georgia Physician Loan Repayment Program, as referenced in O.C.G.A. § 50-36-1, from the Georgia Board of Health Care Workforce, the undersigned applicant verifies one of the following with respect to my application for a public benefit:

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.

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

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).

____________________________________
Signature of Applicant

____________________________________
Printed Name of Applicant

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
___ DAY OF ___________, 20___

_________________________
NOTARY PUBLIC
My Commission Expires:
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 Mariana 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 Mariana 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]
Secure and Verifiable Documents Under O.C.G.A. § 50-36-2
Page 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]
GPLRP Eligible Counties Map for Primary Care
Population of 50,000 or less and Health Professional Shortage Area (HPSA)
GPLRP Eligible Counties Map for Psychiatry Population of 50,000 or less and Mental Health Professional Shortage Area (MHPSA)
I. Practice Site Information

Please type or print with ink

Name of Practice Site: ______________________________________________________________________________________

Address: __________________________________________________________________________________________________

City: _________________________________       State: __________________   Zip Code: ___________________

Practice Phone: __________________________       Practice Ownership:  __________________________________________

Site Description:  __________________________________________________________________________________________
   (e.g., Hospital Clinic, Community Health Center, 330 Clinic, Rural Health Clinic, County owned Clinic, etc.)

Practice Type:  ○ Public   ○ Private Non-Profit*   ○ Private For-Profit

*Attach IRS non-profit documentation, if applicable

County:  ____________________________    Referral Hospital:  ________________________________________

Hospital Address:  _______________________________________________________________________________________

City: _________________________________         State: ___________________   Zip Code:  __________________

Hospital Ownership:_____________________________________________________________________________________

Other towns in practice service area:  _______________________________________________________________________

Name of Provider whose application this Site Application supports:

Name:  ________________________________________________________________________________________________

Address:  _________________________________________________________________________________________________

City: _________________________________   State: ____________________________   Zip Code:  ___________________

Specialty:  ____________________________________________________________________________________________
II. Practice Site Assurances

*Practice Site Official must initial all requirements with which practice entity intends to comply*

**Salary:**

______  Site shall compensate providers at salaries that are competitive with other health professionals in the area.

______  Site shall not use Loan Repayment Program award as a means to reduce provider salaries or offset provider salaries.

**Accessibility:**

______  Providers will accept assignments for Medicare and Medicaid patients.

______  Site uses sliding discount fee schedule that assures no financial barriers to care.

______  Site will conspicuously post a statement of nondiscrimination based on ability to pay.

______  Site has a nondiscrimination policy that prohibits discrimination based on race, creed, disability or religion.

**Comprehensive System of Care:**

______  Providers shall practice in ambulatory care settings that assure the availability of services, including lab and x-ray, pharmacy, after-hours and referral arrangements for services not available on site.

**Provider Employment Contract:**

______  Provider shall practice only in the approved site targeted by the Georgia Physician Loan Repayment Program and named in the provider application as approved by the Georgia Board of Health Care Workforce for a period of at least two years.

______  All providers will have contracts or employment agreements that stipulate providers perform full-time clinical practice defined as a minimum of forty hours per week and a minimum of 45 weeks per year.

______  Site shall communicate with the Georgia Board of Health Care Workforce staff regarding the status of providers, including resignations, terminations and extended leave of absence.

______  Site shall document all circumstances surrounding resignations and terminations.

______  Site must immediately inform the Georgia Board of Health Care Workforce if it is no longer willing or able to comply with any of the above conditions.
III. Practice Site Certification

To be completed by an official authorized to warrant the foregoing on behalf of the practice entity

I certify that the information provided in this application is true and correct as of the date set forth opposite my signature. I also understand that any intentional or negligent misrepresentation(s) of the information contained may result in the forfeiture of our entity’s eligibility to participate in the State Loan Repayment Program.

____________________________________________________________
Signature and Title of practice entity official

____________________________________________________________
Name of practice entity

**Official Notary:**

I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgements, __________________________ (practice official), to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

**WITNESS** my hand and official seal at the City of ______________, County of ________________ and state of ________________.

This ________________ day of ________________, 20___.

____________________________________________________________
Notary Public (Full legal signature)

Affix Seal

My commission expires: __________

**PLEASE RETURN COMPLETED FORM TO:**
Georgia Board of Health Care Workforce
ATTN: Georgia Physician Loan Repayment Program
2 Peachtree Street NW, 6th Floor
Atlanta, Georgia 30303

Questions? Call: 404-232-7972 Or E-mail: GBHCW@dch.ga.gov