

# Georgia Board of Health Care Workforce

**Antonio Rios, MD**  
BOARD CHAIRPERSON



**LaSharn Hughes, MBA**  
EXECUTIVE DIRECTOR

2 Peachtree Street NW, 6<sup>th</sup> Floor • Atlanta, GA 30303  
Main (404) 232-7972 • [healthcareworkforce.georgia.gov](http://healthcareworkforce.georgia.gov) • [gbhcw@dch.ga.gov](mailto:gbhcw@dch.ga.gov)

Dear Applicant:

Enclosed are the required materials for the *Medical/ Dental Malpractice Insurance Premium Grant Application*. The purpose of this program is to increase the number of physicians and dentists whom remain in Georgia to practice in medically underserved rural areas of the state. The grant program shall provide malpractice insurance to those dentists and physicians.

Please submit the following materials by **January 1, 2020**:

- \_\_\_\_\_ Application (pages 2-3), with proper notary signature
- \_\_\_\_\_ Copy of malpractice policy and premium
- \_\_\_\_\_ O.C.G.A. 50-36-1(e)(2) Affidavit (page 4), with proper notary signature
- \_\_\_\_\_ Copy of at least one secure and verifiable document (list provided on pages 5-6)
- \_\_\_\_\_ Payment Reimbursement Form with proof of payment, Vendor Management Form, and W-9 Form.

**All application materials must be completed by this date.** Applications will be presented to the Board at the January 23, 2020 meeting. All applicants will be notified of award status within 10 days of the meeting.

Please contact our office at (404) 232-7972 or Yvette Speight at [yspeight@dch.ga.gov](mailto:yspeight@dch.ga.gov).

Sincerely,

LaSharn Hughes, MBA  
Executive Director

Enclosures

**Georgia Board of Health Care Workforce**  
**Medical/Dental Malpractice Insurance**  
**Premium Grant 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 January 1<sup>st</sup>, 2020. Incomplete applications will not be considered.**

**Applicant's Name** \_\_\_\_\_

*Materials Enclosed With This Packet:*

- \_\_\_\_ Application (pages 2-3), with proper notary signature
- \_\_\_\_ Copy of malpractice policy and premium
- \_\_\_\_ O.C.G.A. 50-36-1(e)(2) Affidavit (page 4), with proper notary signature
- \_\_\_\_ Copy of at least one secure and verifiable document (list provided on pages 5-6)
- \_\_\_\_ Payment Reimbursement Form with proof of payment, Vendor Management Form, and W-9 Form.

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 materials are submitted to GBHCW in the proper timeframe.

**I am a   Physician or   Dentist**

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Applicant Name \_\_\_\_\_

Mail your completed application to:

**Medical/Dental Malpractice  
Insurance Premium Grant**

c/o Georgia Board for Health Care Workforce  
2 Peachtree Street, NW, 6<sup>th</sup> Floor  
Atlanta, Georgia 30303-3141



# Georgia Board of Health Care Workforce Medical/Dental Malpractice Insurance Premium Grant Application

Please type or print CLEARLY in black or blue ink.

## 1. Personal Data

Full Legal Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Email: \_\_\_\_\_

Board Certified: (Circle One) Yes No Specialty: \_\_\_\_\_

Biennial CME Hours: \_\_\_\_\_

Georgia Medical/Dental License #: \_\_\_\_\_

/Number: Medicaid Provider \_\_\_\_\_

Number(s): Medicare Provider \_\_\_\_\_

Number(s): \_\_\_\_\_

## II. Practice Information

Applicant agrees to practice medicine, full time, for one year at:

Practice Site Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Website: \_\_\_\_\_

Number of clinical hours per week at this location: \_\_\_\_\_

Weekend or Extended Hours: \_\_\_\_\_

**III. Certification**

I certify that the information given in this application is accurate and complete to the best of my knowledge. 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. I have fully disclosed my malpractice premium payment information.

\_\_\_\_\_  
**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 oath 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 Board of Health Care Workforce

## O.C.G.A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for the **Medical/Dental Malpractice Insurance Premium Grant 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 this 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:

**Issued August 1, 2011 by the Office of the Attorney General, Georgia**

The Illegal Immigration Reform and Enforcement Act of 2011 (“IIREA”) provides that “[no 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 Islands, 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



## Dental /Medical Malpractice Insurance

### Premium Reimbursement Form

**Recipient:** Payments of your award will be made directly to you.

**Your Name:**

**Please submit copy of cancelled check or bank draft.**

\_\_\_\_\_  
Full Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Email Address

**Name of Malpractice Company**

\_\_\_\_\_  
Full Name

\_\_\_\_\_  
Contact Person

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Account Number

**Reimbursement Amount**

\$ \_\_\_\_\_

**Current Balance**

**Medical/Dental Malpractice Insurance  
Premium Grant**

c/o Georgia Board for Physician Workforce

2 Peachtree Street, NW, 6<sup>th</sup> Floor  
Atlanta, Georgia 30303-3141