

# 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 application materials for the *Physicians for Rural Areas Assistance (PRAA)* Loan Repayment Program. The attached Applicant Information Bulletin gives a description of the program.

The purpose of this program is to grant service cancelable loans of up to \$25,000 to physicians to repay outstanding medical education debt in return for medical practice in underserved rural areas in Georgia. Initial contracts are awarded for a one-year term and are renewable for an additional of three, one year terms.

The Board will consider data published in its most recent Physician Profile in determining the relative need of Health Cares in specific rural areas. The Board will then establish a ranking of locations in the applicant pool. Selection priority will be given to those applicants who are physicians specializing in and actively practicing specialties as approved by the Board at their Annual meeting. The board will consider the following criteria, in rank order: *Health Outcomes, Debt, Total Compensation, Specialty\**, *Practice Type, Live in County of Practice, Other Loan Repayment, County Rank, and Previous Awards.*

\*The board approved the following Primary Care/Core Specialties to be ranked highest: Family Medicine, Internal Medicine, Pediatrics, OB/GYN, Emergency Medicine, General Surgery and Psychiatry. All other specialties will be considered but will be ranked lower than those listed.

Complete the attached PRAA Application, return it with appropriate attachments, postmarked by **December 1st**. **All application materials**, including completed Lender Disclosure Forms, must be received by this date. Applications will be presented to the Board at the next meeting after the application deadline. All applicants will be notified of award status within 10 days of the meeting.

Please contact our office at (404) 232-7972 or [yspeight@dch.ga.gov](mailto:yspeight@dch.ga.gov) if you have questions.

Sincerely,

LaSharn Hughes, MBA  
Executive Director

Enclosures

**GEORGIA BOARD OF HEALTH CARE WORKFORCE**  
**PHYSICIANS FOR RURAL AREAS ASSISTANCE PROGRAM**

**PURPOSE OF THE PROGRAM**

The purpose of the Physicians for Rural Areas Assistance Program is to increase access to high quality medical care for medically underserved, rural communities in Georgia.

**PROGRAM REQUIREMENTS AND CONTRACTUAL OBLIGATIONS**

The Physicians for Rural Areas Assistance Program pays medical education student loan debt of Health Cares who agree to practice medicine full time in a rural community in Georgia. The program provides up to \$25,000 a year in student loan repayment in return for a 12-month commitment to practice in a rural community. Recipients may receive a maximum of four loans for a total student loan repayment of \$100,000.

The Physicians for Rural Areas Assistance Contract requires a commitment to practice medicine for a minimum of 40 clinical hours per week in a Georgia County with a population of **50,000** or less people according to the 2010 Census Count of the United States Bureau of the Census. The practice time requirement can be split between two or more counties, provided that none of the practice location counties exceeds the **50,000** population limit.

The physician may own the practice, or the physician may be employed by a hospital, group medical practice, community health center, or other health care organization. There is no requirement that the practice be a not for profit organization. However, the physician must participate in the Medicaid program, must agree to accept new patients insured by Medicaid, and actively treat Medicaid patients.

Funding is based upon the amount of funds appropriated to the Georgia Board of Health Care Workforce by the Georgia General Assembly. Maximum funding for contracts will be up to \$25,000 each. Funds are disbursed in a lump sum directly to the recipient's lenders.

The Board will consider data published in its most recent Physician Profile in determining the relative need of Health Cares in specific rural areas. The Board will then establish a ranking of locations in the applicant pool. Selection priority will be given to those applicants who are physicians specializing in and actively practicing specialties as approved by the Board at their Annual meeting. The board will consider the following criteria, in rank order: ***Health Outcomes, Debt, Total Compensation, Specialty\****, ***Practice Type, Live in County of Practice, Other Loan Repayment, County Rank, and Previous Awards***.

***\*The board approved the following Primary Care/Core Specialties to be ranked highest: Family Medicine, Internal Medicine, Pediatrics, OB/GYN, Emergency Medicine, General Surgery and Psychiatry. All other specialties will be considered but will be ranked lower than those listed.***

All recipients are required to sign a contract with the Georgia Board of Health Care Workforce agreeing to the terms and conditions upon which awards are granted. This contract establishes the amount of the award, the location of service repayment, the contract date (also the beginning and end date of service), as well as the terms and conditions of program participation, obligated service, and the conditions of default and cash repayment.

## **ELIGIBLE STUDENT LOANS**

Student loans incurred for tuition, fees, and other expenses associated with completion of your medical degree are eligible for payment under the Physicians for Rural Areas Assistance Program.

Student loan debt incurred to complete other academic degrees is not eligible for payment under the Physicians for Rural Areas Assistance Program.

## **APPLICATION REQUIREMENTS**

Eligible Applicants must:

- Be a citizen or national of the United States;
- Have satisfied all requirements for unrestricted medical licensure by the Georgia Composite Medical Board;
- Be a graduate of an accredited 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;
- Hold a Medicaid Provider Number in Georgia and actively treat Medicaid Patients;
- Be in good standing with regard to meeting the contractual requirements of all existing student loans. Applications will not be considered if the applicant has had a previous loan default even if the lender now considers the defaulted loan in good standing;
- Submit an application and all required materials to participate in the Physicians for Rural Areas Assistance Program no later than December 1st. (Submitting an application does not guarantee selection);
- Disclose all outstanding **medical** education loan debt; If loans have been consolidated, submit documentation showing dates of original loan disbursement;
- Submit executed copy of employment contract. If self-employed in private practice, applicant must submit a copy of any hospital agreements/contracts;
- Contractually agree to practice full-time (minimum of 40 clinical hours per week);
- Submit a copy of most recent Federal Income Tax return and W-2s showing total compensation;
- Complete and notarize Affidavit of Lawful Presence in the United States (form provided) and submit a copy of an approved secure and verifiable document (from provided document list); and
- Have completely satisfied any other obligation for health professional service owed under any agreement with the Federal Government, State Government, or other entity prior to beginning service under this program

**NOTE:** Applicants who are recipients of the GBPW (formerly the State Medical Education Board) Scholarship Program must extend their period of service obligation by the period of service obligation required by the Physicians for Rural Areas Assistance Program.

## **APPLICATION PROCESS**

Completed applications must be received no later than **December 1st** for consideration during the fiscal year. Applications will not be considered complete unless **ALL** application materials, including completed Lender Disclosure Forms, are received by this date.

All information requested in the Application must be complete prior to Board consideration.

Further information is available by contacting the Board office. The Board may request that the candidate make a personal appearance before the Board, although this is not typically the case.

A Notice of Award letter and Acceptance of Award form will be mailed to those applicants approved by the Board. Upon receipt of the Acceptance of the Award form, the Board will issue a Physicians for Rural Areas Assistance Program contract. Payment of the Award is made once the contract is fully executed.

Recipients may reapply for additional one-year terms for a maximum of four years or up to \$100,000. Each recipient is required to complete and submit an annual status report to the Board.

## **CONTRACT DEFAULT**

The contract includes a penalty of double the principal award amount received for:

- Failure to begin or complete the full twelve-month service commitment in the location named in the contract;
- Failure to meet the 40 clinical hours per week full-time practice commitment (as defined in Chapter 195-12-.01(20) of the Official Rules of the GBPW); or
- Failure to provide Board staff with access records and other information necessary to document compliance with contract terms.

The cost of attorney fees and other expenses associated with collection are assessed in addition to the double default penalty.

## **FURTHER INFORMATION AND ASSISTANCE**

Please contact us if you have questions or need additional information.

Georgia Board of Health Care Workforce

2 Peachtree Street, NW,

6<sup>th</sup> Floor Atlanta, Georgia 30303

404-232-7972-Office

404-656-2596-Fax

Email [yspeight@dch.ga.gov](mailto:yspeight@dch.ga.gov)

[www.gbpw.georgia.gov](http://www.gbpw.georgia.gov)

Georgia Board of Health Care Workforce  
**Physicians for Rural Areas Assistance**  
**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 December 1<sup>st</sup>.**

**Applicants Name** \_\_\_\_\_

**Materials Enclosed with This Packet:**

- \_\_\_\_\_ PRAA Application (pages 6-9), with proper notary signature
- \_\_\_\_\_ Authorization and Release Form (page 11), with proper notary signature
- \_\_\_\_\_ O.C.G.A. 50-36-1(e)(2) Affidavit (page 12), with proper notary signature
- \_\_\_\_\_ Copy of at least one secure and verifiable document (list provided on pages 13-14)
- \_\_\_\_\_ 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 GBPW):**

\_\_\_\_\_ Lender Disclosure form(s) (page 10) 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 **December 1<sup>st</sup>** may not be considered.

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

Mail your completed application to:

**Physicians for Rural Areas Assistance Program**

Georgia Board of Health Care Workforce

2 Peachtree Street, NW, 6<sup>th</sup> Floor

Atlanta, Georgia 30303-3141



**Georgia Board of Health Care  
Workforce**

**Physician Rural Areas Assistance**

**Loan Repayment Program Application**

**I. Personal Data**

Please type or print CLEARLY in black ink

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

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

Must provide street address. No P.O. Boxes

Maiden Name(s): \_\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_ SSN: \_\_\_\_\_

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

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

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

**II. Specialty Practicing**

- Family Medicine       General Pediatrics       General Internal Medicine
- Obstetrics/Gynecology       Emergency Medicine       General Surgery
- Psychiatry       Other \_\_\_\_\_

Do you work as a/an: Hospitalist  Yes  No?

Emergency Room Doctor  Yes  No?

**III. Medical Education**

Medical School: \_\_\_\_\_ Graduation Date: \_\_/\_\_/\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Degree:  MD  DO

Residency Hospital: \_\_\_\_\_ Specialty: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Graduation Date: \_\_/\_\_/\_\_\_\_

Residency Hospital: \_\_\_\_\_ Specialty: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Graduation Date: \_\_/\_\_/\_\_\_\_

Board Certified:  Yes  No      Board Eligible:  Yes  No

Georgia Medical License #: \_\_\_\_\_ Medicaid Provider # \_\_\_\_\_

**IV. Practice Information**

Applicant agrees to provide full time, primary care in \_\_\_\_\_ for one year at:  
Medical Specialty

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

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

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

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

Type of Practice:  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?  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:  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?  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** education 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.\*If loans have been consolidated, submit documentation showing dates of original loan disbursement;

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: \$ \_\_\_\_\_



**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 oath and take acknowledgements, \_\_\_\_\_ (applicant's name), to me known to be the persona 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: \_\_\_\_\_

Physicians for Rural Areas Assistance 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 **December 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. Please return completed form to:  
*GBPW, 2 Peachtree Street, NW, 6<sup>th</sup> Floor, Atlanta, GA 30303-3141*

**Applicant's name as it appears on loan:** \_\_\_\_\_

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

Full Name of Institution or Program	Contact Person	Telephone Number
Street Address	City	State
_____	_____	_____
<b>Loan ID Number</b>	\$ _____ Original Loan Amount	_____
_____	\$ _____ Current Balance	_____
Grace Period/Forbearance Dates	_____	Date of Original Loan
_____ %	_____	_____
Interest Rate	_____	Date of Balance
_____	Simple or Compound	_____

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 Physicians for Rural Areas Assistance 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 - PHYSICIANS FOR RURAL AREAS ASSISTANCE 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 \_\_\_\_\_ Title

Official Signature: \_\_\_\_\_

**Lender Organization's Federal Employer Identification Number:** \_\_\_\_\_

**GEORGIA BOARD OF HEALTH CARE WORKFORCE**  
**Authorization and Release Form**  
**Physicians for Rural Areas Assistance 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

Physicians for Rural Areas Assistance 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 inquires, 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 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: December 2016

**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 **PRAA 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  
THIS \_\_\_\_\_ 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 (“IIRA”) 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]

**Secure and Verifiable Documents Secure O.C.G.A. § 50-36-2(b)(3)**

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- 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]