Georgia Board for Physician Workforce

2 Peachtree Street NW, 6th Floor
Atlanta, GA 30303
Main (404) 232-7972 - Fax (404) 656-2596
www.gbpw.georgia.gov - gbpw@dch.ga.gov

Practice Site Application-GPLRP Loan Repayment Program

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 Internal Revenue Services 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 tends 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 for Physician 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 for Physician 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 for Physician 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 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:_____

Mail your completed application to:

Georgia Board for Physician Workforce

GPLRP Program

2 Peachtree Street, N.W., 6th Floor

Atlanta, Georgia 30303

Direct questions to 404-232-7972

E-mail: gbpw@dch.ga.gov

Website: www.gbpw.georgia.gov