

Georgia Board for Physician Workforce

Antonio Rios, MD
BOARD CHAIRPERSON



LaSharn Hughes, MBA
EXECUTIVE DIRECTOR

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

Dear Applicant:

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

Please submit the following materials by **April 1, 2019**:

- _____ 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 April 18, 2019 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.

Sincerely,

LaSharn Hughes, MBA
Executive Director

Enclosures

Georgia Board for Physician Workforce
Medical 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 April 1, 2019. 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 GBPW in the proper timeframe.

Applicant Signature _____ Date _____

Print Applicant Name _____

Mail your completed application to:

Medical Malpractice Insurance Premium Grant

c/o Georgia Board for Physician Workforce

2 Peachtree Street, NW, 6th Floor
Atlanta, Georgia 30303-3141



Georgia Board for Physician Workforce Medical 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 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 for Physician Workforce

O.C.G.A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for the **Medical Malpractice Insurance Premium Grant Program**, as referenced in O.C.G.A. § 50-36-1, from the **Georgia Board for Physician 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



Malpractice Insurance Premium Reimbursement Form

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

Please submit copy of cancelled check or bank draft.

Your Name:

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 Malpractice Insurance Premium Grant

c/o Georgia Board for Physician Workforce

2 Peachtree Street, NW, 6th Floor
Atlanta, Georgia 30303-3141