



# Georgia Board for Physician Workforce

State of Georgia

All Scholarship Applicants:

Enclosed are application materials for the Georgia Board for Physician Workforce Scholarship Program. The scholarship amount for the 2013-2014 academic year will be up to \$20,000. Pending the availability of funding, scholarships may be renewed, on an annual basis, three times, providing qualified applicants with up to four scholarships.

The enclosed information includes materials describing the requirements of the program. Please note that by obtaining a scholarship you agree to practice medicine full-time (a minimum of 40 hours per week) in a Board-approved Georgia county having a population of 35,000 or less. The authority for county populations is the Decennial Census Count of the United States Bureau of the Census effective at the time the scholarship contract is signed. You may also practice full-time, a minimum of 40 hours per week, at any facility operated under the jurisdiction of the Georgia Department of Public Health, Georgia Department of Behavioral Health and Developmental Disabilities, Georgia Department of Corrections, or the Georgia Department of Juvenile Justice at the conclusion of your medical training.

In order for your application to be considered by the Board, you must submit **all** the following documents postmarked or hand delivered by **June 1, 2013**:

1. Completed Application Form (include a recent black and white photo)
2. Completed Certification of Residency Form (form enclosed)
3. Letter of acceptance to an accredited medical school (If you have not yet been accepted, submit all other application documents pending your acceptance)
4. Completed Applicant Financial Information Forms (forms enclosed)  
\*Applicants wishing to display substantial financial hardship should include a copy of their Student Aid Report (SAR), the official summary of the Free Application for Federal Student Aid (FAFSA)
5. Copy of most recent 1040 or 1040EZ Forms (or other applicable tax forms)
6. Copy of the personal statement from your medical school application
7. Transcript of your grades, if currently enrolled in medical school
8. Selective Service Information for all male applicants (form enclosed)
9. Authorization and Release Form (form enclosed)
10. Completed and notarized Affidavit of Lawful Presence in the United States (form enclosed) with a copy of an approved secure and verifiable document

After receipt of all application materials, all scholarship applicants will be **required** to attend a formal interview with the members of the Board in July.

If you desire additional information or assistance with your application, please write or call this office at (404) 232-7972.

Sincerely,

*Cherri Tucker*

Cherri Tucker  
Executive Director

Enclosures

# The Georgia Board for Physician Workforce

## Scholarship Program

Academic Year 2013-2014



### Applicant Information Bulletin

This document describes the Georgia Board for Physician Workforce Scholarship Program. Program participants will be bound by contract to adhere to the provisions outlined in this document.

*Please keep this Bulletin for future reference.*

# GEORGIA BOARD FOR PHYSICIAN WORKFORCE SCHOLARSHIP PROGRAM

## PURPOSE OF THE PROGRAM

The Georgia Board for Physician Workforce Scholarship Program was created in 1952 to provide a supply of physicians for rural areas of the State and to help defray the cost of medical school for Georgia residents who desire to practice medicine in rural Georgia. The service repayable scholarship will provide up to \$20,000 per year to help pay the cost of medical school in return for a contractual obligation to practice medicine full-time (a minimum of 40 hours per week) in a Board-approved Georgia county with a population of 35,000 or less.

## ELIGIBLE APPLICANTS

All applicants must be legal residents of the State of Georgia and citizens of the United States. In order for an application to be considered by the Board, the applicant must be accepted into an L.C.M.E. or A.O.A. accredited four-year medical school located in the United States offering the degrees of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) All scholarship recipients must pursue a course of study that will allow them to qualify for licensure by the Georgia Composite Medical Board.

Successful applicants must exhibit a strong commitment to practice medicine in rural Georgia (a Board-approved Georgia county having a population of 35,000 or less.) Additional priority will be given to those applicants who demonstrate financial need. The applicant is required to disclose his/her own financial information. **Applicants who currently hold other service obligations are not eligible to apply.**

## APPLICATION REQUIREMENTS

1. Completed application form (form provided)
2. Completed Certificate of Residency (form provided)
3. Male applicants are required to submit evidence of having registered for Selective Service (form provided)
4. Financial information as to the inability of the applicant to finance his or her medical education (forms provided)
  - \* Applicants wishing to display substantial financial hardship should include a copy of his or her Student Aid Report (SAR), the official summary of the Free Application for Federal Student Aid (FAFSA)
5. Copy of most recent 1040 or 1040EZ Forms (or other applicable tax forms)
6. Letter of acceptance to an accredited medical school
7. Copy of personal statement from medical school application
8. Completed Authorization and Release Form (form provided)
9. Transcript of grades, if currently enrolled in medical school
10. Completed and notarized Affidavit of Lawful Presence in the United States (form provided) with a copy of an approved secure and verifiable document
11. Attend the formal applicant interviews conducted by the Board at the July meeting

The Board is charged with receiving and acting upon all applications for scholarships made by students who are residents of Georgia who desire to become doctors and who make a contractual commitment to practice medicine full-time (at least 40 hours per week) in an approved Georgia community.

## **FINANCIAL HARDSHIP**

Applicants wishing to display a substantial financial hardship should submit a copy of his or her Student Aid Report (SAR), the official summary of the Free Application for Federal Student Aid (FAFSA.) This report will be used by the Board in assessing the financial need of the applicant outside of the GBPW provided financial forms. Applicants need only include this report if demonstrating substantial financial need for scholarship funding.

## **CONTRACTUAL OBLIGATIONS**

All scholarship recipients are required to sign a contract with the Georgia Board for Physician Workforce agreeing to the terms and conditions upon which the scholarships are granted. This contract establishes the amount of the scholarship award, the date of the contract, and the corresponding census count used to determine eligible practice locations, as well as the terms and conditions of program participation pertaining to medical training, obligated service, and the conditions of default and cash repayment.

For each year of full-time medical practice in a Board-approved Georgia county having a population of 35,000 or less, or at any hospital or facility operated under the jurisdiction of the Georgia Department of Public Health, Georgia Department of Behavioral Health and Developmental Disabilities, the Georgia Department of Corrections, or the Georgia Department of Juvenile Justice, the recipient will receive credit for the amount of scholarship funds which he or she received during any one year in medical school. The authority for county populations is the Decennial Census Count of the United States Bureau of the Census effective at the time the scholarship contract is signed.

## **AWARDING AND FUNDING OF SCHOLARSHIPS**

Scholarship funding is based upon the amount of funds appropriated to the Georgia Board for Physician Workforce by the Georgia General Assembly. The funding amount for scholarship awards during the 2013-2014 academic year will be up to \$20,000 each. Upon the submission of a signed contract and verification that the student is enrolled in the medical school named in said contract, scholarship funding is authorized. Scholarship funds are disbursed directly to the medical school to address yearly tuition and fees with any remaining funds being disbursed to the student by his/her medical school.

## **CONTRACT RENEWAL**

The contract term is one year. Contracts may be renewed for an additional one-year term for a maximum of four years. Each scholarship recipient is required to complete and submit an annual report to the Board concerning their status in training.

The Annual Report includes:

1. All current and valid contact information
2. Medical school enrollment status and verification of good academic standing
3. Date of graduation
4. Plans for specialization
5. Continued interest and recommitment to rural practice

## **SCHOLARSHIP REPAYMENT OBLIGATIONS**

Each recipient is required to obtain Board approval of any proposed practice location. Credit for practice

repayment is applied as one year of funding for each year of service rendered in compliance with the repayment provisions of the scholarship contract. Practice without written Board approval will not be credited toward the satisfaction of the contractual service obligation.

The recipient must practice full-time, a minimum of forty hours per week, in the Board approved practice location. If a recipient changes practice location for any reason, he/she must request Board approval of any subsequent practice location.

## **STUDENTS DISMISSED OR WITHDRAWN**

In the event a scholarship recipient is dismissed from medical school for either academic or disciplinary reasons, or a recipient voluntarily withdraws from medical school, the scholarship recipient is immediately liable for all scholarship funds received, plus accrued interest at the rate stated in the scholarship contract.

## **CONTRACT DEFAULT**

A scholarship recipient will be considered in default under any of the following circumstances:

1. Failure to keep the Board informed of current contact information (phone, address, etc.)
2. Failure to submit reports, forms, transcripts, etc., as required by the Board
3. Failure to obtain Board approval of practice location
4. Failure to begin or complete approved practice obligation
5. Failure to maintain a full-time (minimum of forty hours per week) medical practice
6. Failure to obtain and maintain a valid medical license from the Georgia Composite Medical Board

**In the event the Georgia Board for Physician Workforce finds a scholarship recipient in default, the recipient is immediately liable for triple the principal amount of scholarship funds received.**

## **PRACTICE LOCATION ASSISTANCE**

The Georgia Alliance of Community Hospitals now sponsors the annual Medical Fair in conjunction with the Georgia Board for Physician Workforce and the Georgia Rural Health Association. This function is designed to enable physicians to meet representatives from 35-40 qualifying rural Georgia communities to discuss practice opportunities in our State. Please check their website at [www.gach.org](http://www.gach.org) for information on the 2013 fair.

The Georgia Board for Physician Workforce maintains information pertaining to practice opportunities statewide. Many of these opportunities are rural locations eligible for repayment of the scholarship obligation. In addition, the staff of the Board, through contact with scholarship recipients in practice and rural Georgia communities, will provide information pertaining to practice opportunities from time to time. However, each scholarship recipient is responsible for securing a qualifying practice location for themselves. The GBPW is NOT responsible for locating a suitable practice site for recipients.

## **OBTAINING AN APPLICATION**

Applications are available from the Georgia Board for Physician Workforce at any time by phone request, on the website, [www.gbpw.georgia.gov](http://www.gbpw.georgia.gov), or by email at [gbpw@dch.ga.gov](mailto:gbpw@dch.ga.gov). Completed applications **must** be received in the Georgia Board for Physician Workforce office no later than June 1, 2013 for consideration.

**For applications or additional information, please contact:**

Georgia Board for Physician Workforce  
Scholarship Program  
2 Peachtree Street, NW, 36<sup>th</sup> Floor  
Atlanta, Georgia 30303-3141  
Telephone: 404-232-7972  
Fax: 404-656-2596  
Email: [gbpw@dch.ga.gov](mailto:gbpw@dch.ga.gov)  
Website: [www.gbpw.georgia.gov](http://www.gbpw.georgia.gov)

Attach recent photo, preferably with a light background. Attach with paper clip ONLY!!

## APPLICATION

**Georgia Board for Physician Workforce  
Scholarship Program**

**Georgia Board for Physician Workforce  
2 Peachtree St., NW, 36<sup>th</sup> Floor  
Atlanta, Georgia 30303-3141  
Telephone: 404-232-7972  
Fax: 404-656-2596**

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Please print or type legibly

### PERSONAL HISTORY:

Full Legal Name: \_\_\_\_\_  
Last First Middle/Maiden

SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Permanent Mailing Address: \_\_\_\_\_  
Street/Apt/Box No. City State Zip

Current Mailing Address: \_\_\_\_\_  
Street/Apt/Box No. City State Zip

Date this address will change: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Birthplace: City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_

Hometown in Georgia: \_\_\_\_\_ Age: \_\_\_\_\_ Number of Years You Have Resided in Georgia: \_\_\_\_\_

List other places of residence and the number of years in each place: \_\_\_\_\_  
\_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouse's Hometown: \_\_\_\_\_

Name of contact person who will always know your whereabouts:

Full Name \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

Address: \_\_\_\_\_  
Street/Apt/Box No. City State Zip Phone

## EDUCATIONAL HISTORY

School	Name, City/State	Year Entered	Year Graduated	Diploma/Degree
<b>High School</b>				
<b>College</b>				

SAT Score: \_\_\_\_\_ or ACT Score: \_\_\_\_\_

MCAT Scores: Biological Science \_\_\_\_\_ Physical Science \_\_\_\_\_ Verbal Reasoning \_\_\_\_\_ Writing \_\_\_\_\_

GPA: Last Academic Year: \_\_\_\_\_ Overall GPA: College \_\_\_\_\_ Medical School \_\_\_\_\_

**Medical School You Plan to Attend:** \_\_\_\_\_

If presently enrolled, please check class rising: Second Year \_\_\_\_\_ Third Year \_\_\_\_\_ Fourth Year \_\_\_\_\_

**Offices and Honors:** \_\_\_\_\_

## EMPLOYMENT HISTORY:

If you worked while in school during afternoons, weekends, holidays, summers, etc., give detailed information as requested:

Year	Place of Employment	Duties	Length of Employment	Total Earnings
<b>(HIGH SCHOOL)</b>				
Fr.				
Soph.				
Jr.				
Sr.				
<b>(COLLEGE)</b>				
Fr.				
Soph.				
Jr.				
Sr.				
<b>(PRESENT EMPLOYMENT)</b>				

Indicate How Your College and Medical School Expenses Have Been Paid:

	<u>College</u>	<u>Medical School</u>
Paid by Earnings	_____ %	_____ %
Paid by Parents	_____ %	_____ %
Paid by Scholarships	_____ %	_____ %
Paid by Loans	_____ %	_____ %
Other Sources, Please list:		
_____	_____ %	_____ %
_____	_____ %	_____ %
	100%	100%

Total Present Educational Indebtedness: \$ \_\_\_\_\_

List Scholarships Received by Year, Amount and Institution: \_\_\_\_\_

Are any of these scholarships service cancellable? Yes No If so, which? \_\_\_\_\_

*\*GBPW Scholarship recipients cannot hold other service cancellable scholarships or loans.*

Other Sources of Income (if any): \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Amount Spouse Contributes to Your Medical Education: \$ \_\_\_\_\_

*The foregoing information is true and correct to the best of my knowledge and belief. I understand that if I receive and accept a Georgia Board for Physician Workforce Scholarship, I will be required to practice medicine on a full-time basis(at least 40 hours per week) in a Board-approved county of 35,000 population or less, according to the Decennial Census Count of the United States Bureau of the Census effective at the time the scholarship contract is signed, or a position with the Georgia Departments of Juvenile Justice, Corrections, Public Health or Behavioral Health and Developmental Disabilities. For each year of practicing my profession in such location, I will receive credit for the amount of scholarship I received during one year of medical school. I further understand that my residency program must be approved by the Board.*

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**Official Notary:**

I hereby certify that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgements, \_\_\_\_\_ (applicant's name), to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledged 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\_\_\_\_.

\_\_\_\_\_  
Notary Signature

My commission expires: \_\_\_\_\_  
(Affix Seal)

**PRACTICE PREFERENCES**

Please list 3 Georgia counties in which you are interested in practicing. Your choices are limited to counties having a population of 35,000 or less, or positions with Georgia Departments of Corrections, Public Health, Behavioral Health and Developmental Disabilities, or Juvenile Justice.

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**REMARKS:** Information not requested in the application that you feel may be pertinent to your application.

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# GEORGIA BOARD FOR PHYSICIAN WORKFORCE Scholarship Application

## APPLICANT FINANCIAL INFORMATION All information provided will remain confidential

Please respond to every question, using n/a or "0" if necessary. Please type or print legibly.

1. Full Name \_\_\_\_\_
2. Permanent Mailing Address \_\_\_\_\_  
Street Apt. Number E-mail Address  
\_\_\_\_\_  
City State Zip Area Code/Telephone Number
3. State of Legal Residence \_\_\_\_\_
4. List the number of years (in each city) you have resided in Georgia (i.e., 18, Atlanta; 5, Rome) \_\_\_\_\_  
\_\_\_\_\_  
List all other states in which you have resided, along with the number of years (i.e., 4, Ohio) \_\_\_\_\_  
\_\_\_\_\_
5. Citizenship: \_\_\_\_\_ U.S. Citizen \_\_\_\_\_ Resident Alien \_\_\_\_\_ Other, please specify \_\_\_\_\_
6. Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female
7. Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed
8. Will you have received your undergraduate degree by July 1, 2013? \_\_\_\_\_  
List your undergraduate field of study \_\_\_\_\_
9. Expected degree (M.D./D.O.) \_\_\_\_\_ Expected date of graduation \_\_\_\_\_
10. Did you live with your parents during all or part of 2012? \_\_\_\_\_
11. Did your parents claim you as a tax exemption during 2012? \_\_\_\_\_
12. Did you receive more than \$750 support from your parents during 2012? \_\_\_\_\_
13. The total size of your household during 2012 (include yourself, spouse and dependent children) \_\_\_\_\_
14. List number of dependent children and ages \_\_\_\_\_
15. Of the number in question 13, how many will be in college (full or part-time) during 2013-2014? \_\_\_\_\_
16. **Spouse Information:**
  - A. Name \_\_\_\_\_ Age \_\_\_\_\_ Hometown \_\_\_\_\_
  - B. Occupation \_\_\_\_\_ Employer \_\_\_\_\_
  - C. Will spouse attend college in 2013-2014? \_\_\_\_\_
  - D. Does spouse have relatives or living experience in rural areas? \_\_\_\_\_
17. **Applicant and Spouse's Resources during 2012:**
  - A. Applicant's wages, salaries, tips, etc. (before taxes and deductions) \$ \_\_\_\_\_

- B. Spouse's wages, salaries, tips, etc. (before taxes and deductions) \_\_\_\_\_
- C. Other taxable income (interest, dividends, etc.) \_\_\_\_\_
- D. Social Security benefits \_\_\_\_\_
- E. Military/Veteran's benefits \_\_\_\_\_
- F. Support from Applicant's parents \_\_\_\_\_
- G. Support from Spouse's parents \_\_\_\_\_

TOTAL RESOURCES \$ \_\_\_\_\_

18. Monthly home mortgage or rental payment: \$ \_\_\_\_\_

19. If you own a home: Year Purchased \_\_\_\_\_ Purchase Price \$ \_\_\_\_\_

20. Applicant and Spouse's Assets:	<u>Present Value</u>	<u>Amount of Debt</u>
A. Cash, savings, checking accounts	\$ _____	\$ _____
B. Home (Renters, write "0")	_____	_____
C. Investments (type: _____)	_____	_____
D. Business (type: _____)	_____	_____
E. Farm (type: _____)	_____	_____
TOTAL ASSETS	\$ _____	\$ _____

21. Please estimate your 2013 income: Applicant \$ \_\_\_\_\_ Spouse \$ \_\_\_\_\_

Will your combined total income differ significantly from the 2012 income reported above? \_\_\_\_\_  
 If yes, please explain: \_\_\_\_\_

22. List all other types of financial aid for which you have applied (*HEAL, Stafford, In-House Medical Loans, NHSC, Military Scholarship, Osteopathic Student Loan, etc.*) \_\_\_\_\_  
 \_\_\_\_\_ Are any of these service cancellable? Yes No If so, which? \_\_\_\_\_

23. Comments or explanations of any special circumstance (give number of question to which you are referring):  
 \_\_\_\_\_  
 \_\_\_\_\_

**THE FOREGOING IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
 Applicant's Signature Date

\_\_\_\_\_  
 Spouse's Signature Date

**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 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 the City of \_\_\_\_\_, County of \_\_\_\_\_ and State of \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
 Notary Public  
 Affix Seal

# REQUIRED REGISTRATION FOR MILITARY SERVICE

All MALE students born AFTER December 31, 1959 must complete and submit this form with the application for scholarship consideration.

“Article 1 of Chapter 3 of Title 20 of the Official Code of Georgia Annotated, relating to definitions affecting post-secondary education, has been amended by adding at the end of said article a new Code section, to be designated Code Section 20-3-2, to read as follows:

20-3-2. Except as otherwise allowed by law, no person who is required to register for the federal military service draft under 50 U.S.C. Section 453, as amended, shall be eligible to receive any form of state funds under this chapter, including appropriations, grants, bond proceeds, or any other form of funds, unless such person has registered for the draft.”

Have you registered for the draft?                     Yes             No

If so, what is your draft number?                    \_\_\_\_\_

The above information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print your name here

To obtain your draft number, call the Selective Service System at **1-847-688-6888**.

You will need your social security number to identify yourself.

To register online, go to **www.sss.gov**

**GEORGIA BOARD FOR PHYSICIAN WORKFORCE  
AUTHORIZATION and RELEASE FORM**

**FULL LEGAL NAME OF APPLICANT:** \_\_\_\_\_

TO WHOM IT MAY CONCERN:

I, \_\_\_\_\_, have filed an application with the Georgia Board for  
*Applicant's Full Legal Name*

Physician Workforce for a medical scholarship to defray the cost of my tuition and other expenses while attending medical school. I recognize that it is the responsibility of the members of said Board to determine that only those qualified persons of high character and recognized ability, who have demonstrated a financial need, are eligible for the award of scholarships. To this end, and for the entire contract period and any subsequent contractual period, I hereby authorize and request any college or school official, 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 for Physician 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 the Georgia Board for Physician 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 for Physician Workforce, who shall comply in good faith with this authorization and release 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 for Physician 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 Sections 38-418, 38-419.1 of the Georgia Code 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** \_\_\_\_\_

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**OFFICIAL NOTARY:**

**I HEREBY CERTIFY** that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments, \_\_\_\_\_, to me well known to be the person

**Applicant's Full Legal Name**

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\_\_.

\_\_\_\_\_  
My Commission Expires: \_\_\_\_\_

\_\_\_\_\_  
Legal Signature, Notary Public

**(Place Seal Imprint Here)**

**O.C.G.A. § 50-36-1(e)(2) Affidavit of Lawful Presence in the United States**

By executing this affidavit under oath, as an applicant for a(n) Medical School Scholarship [type of public benefit], as referenced in O.C.G.A. § 50-36-1, from the Georgia Board for Physician Workforce [name of government entity], 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 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]
- 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 public benefit