



# 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.

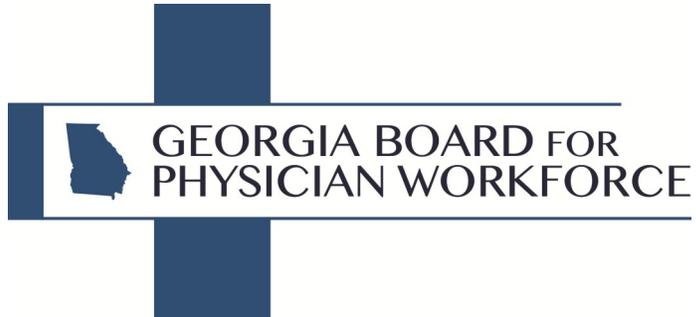
**WITNESS** my hand and official seal at the City of \_\_\_\_\_, County of \_\_\_\_\_ and state of \_\_\_\_\_

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 Loan Repayment Program  
2 Peachtree Street, N.W., 36th Floor  
Atlanta, Georgia 30303

Direct questions to 404-232-7972

E-mail: [gbpw@dch.ga.gov](mailto:gbpw@dch.ga.gov)

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