GEORGIA DEPARTMENT OF COMMUNITY HEALTH

State Office of Rural Health and Primary Care
Georgia Department of Community Health
502 South Seventh Street
Cordele, GA 31015-1443
(229) 401-3090

SEMIANNUAL REPORT

_____
Reporting Period

PHYSICIAN NAME: _____ Specialty: _____

Home Address: _____

Phone Number: _____ Email: _____

EMPLOYER NAME: _____

Employer Point of Contact (Name, Title): _____

Contact Phone: _____ Email: _____

PRACTICE SITE NAME & ADDRESS(ES): _____

_____

_____

1) Number of hours per week J-1 physician provided direct patient care during this reporting period: _____
2) Number of days J-1 physician was absent due to leave of absence in excess of accrued paid time off: _____
3) Number of unduplicated patients during this reporting period (NOT number of patient visits): _____
4) Patient breakdown by primary payer source for this reporting period (total should equal 100%):
   a. Medicare _____%
   b. Medicaid (include CHIP/PeachCare/CMOs) _____%
   c. Private Insurance _____%
   d. Self-Pay / No Insurance _____%
5) Number of self-pay patients utilizing sliding fee schedule during this reporting period: _____
6) Percentage of patients residing in the same county in which the practice site is located: _____%

I hereby certify that I provided medical care services as described in this report and that all information contained in this report is true to the best of my knowledge and belief.

_____ _____
Signature of J-1 Physician Date

I hereby certify that the aforementioned physician provided medical care services as described in this report and that all information contained in this report is true to the best of my knowledge and belief.

_____ _____
Employer Signatory (Type/Print Name) Title

_____ _____
Signature of Employer Date