

Gwinnett Managed Care, Inc.
A Physician Hospital Organization (PHO)

FWA TRAINING MATERIALS ATTESTATION FORM

I, _____ (“Provider”) have received, reviewed and understand the FWA Training and Code of Conduct provided by Gwinnett Managed Care, Inc. on _____. I agree to abide by and use reasonable efforts to ensure that my staff abide, by all principles therein, regulations and laws.

Signature

Provider Name / Group

Date

Return Attestation Form to:

Name Stacy Godfrey
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Email stacy.godfrey@northside.com
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