**Gwinnett Managed Care, Inc. / Sequent Health Physician Partners**

**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./ Sequent Health Physician Partners 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

Mailing Address P O Box 1417, Lawrenceville, GA 30046

Email stacy.godfrey@northside.com

Fax 678-312-5569