



PRE-OPERATIVE PEDIATRIC INFORMATION PACKET

Thank you for choosing Augusta ENT for your healthcare needs. You will be scheduled for surgery at the ENT Surgery Center of Augusta located at the back of our Evans office at 340 North Belair Road. This packet is your Pre-Operative information. Please read each page and follow the directions carefully.

Patient Notification (For you to keep)

You **MUST** read this page **BEFORE** your surgery. It informs you of your rights and responsibilities as a patient.

Please fill out, sign, and bring with you on the day of your surgery:

1. **Lab Release Form** – You may need to call the phone number on your insurance card or your caseworker to find out this information. This is to avoid sending anything to a lab that is not in your network which would create unnecessary out-of-pocket expenses for you.
2. **Pre-op Instructions**
3. **Medication Reconciliation Form**
4. **Anesthesia History & Physical**

Eating and Drinking Rules (For you to keep)

You will be given instructions over the phone about eating and drinking the day before your surgery. This page serves as another reminder of those rules.

Please call our office if you have any questions. (706) 868-5676, ext. 756

Arrival Time

You will receive a phone call the work day before your surgery day telling you the time you need to arrive at the surgery center. Example: If your surgery is on Monday, you would receive a call the Friday before.

Billing Information

Your charges for the surgery center are **separate** from your doctor/surgeon and anesthesia.

You can expect to receive up to 4 bills for your visit:

1. **Facility** - The ENT Surgery Center of Augusta
2. **Doctor** - From the physician that performed the surgery.
3. **Anesthesia** - From the anesthesiologist that put you to sleep
4. **Pathology** - If specimens were obtained. Your doctor will inform you and/or your family member after the procedure if specimens were sent to the lab.

It is the policy of this center to collect co-pays and/or deductibles prior to or on the day of surgery. You should receive a call from our business office if there will be any payment due prior to your surgery.

If you have any questions about billing please call (706) 868-5676 ext. 738 or ext. 659.



PATIENT NOTIFICATION
ENT Surgery Center of Augusta
340 North Belair Rd, Evans, GA 30809
706-364-4040 Fax 706-364-8402

PATIENT RIGHTS

The ENT Surgery Center would like to assure you of your rights and responsibilities as a patient.

You have a right to:

- Considerate, respectful & dignified care provided in a safe environment, free from all forms of abuse, neglect harassment and/or exploitation.
- Personal and informational privacy, within the law.
- Information concerning your diagnosis, treatment & prognosis, to the degree known in a language or manner you understand, or to an individual designated by you or to a legally authorized individual as part of the informed consent process.
- Appropriate assessment and management of pain.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns of your health.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Know and inquire about the identity & professional status of individuals providing service.
- Request a change in providers of care if other qualified providers are available.

HEALTHCARE PRACTITIONERS IN THIS FACILITY

This surgery center employs Medical Doctors, Doctors of Osteopathy, Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, Certified Surgical Technicians, Surgical Technicians and Operating Room Technicians.

PATIENT COMPLAINT OR GRIEVANCE

The ENT Surgery Center will promptly review, investigate & resolve any patient grievances or complaints in a timely manner. If you feel you may have an issue, we provide you with the following contact information:

ENT Surgery Center of Augusta
340 North Belair Rd, Evans, GA 30809
Attention: Keith Lynn, Administrator
(Within 20 working days you will receive written notice of the status of your grievance from Mr. Lynn.)

Georgia Dept. of Community Health
ATTN: Complaints Dept
2 Peachtree Street, Suite 3100
Atlanta, GA 30303-3142
404-657-5726
1-800-878-6442
<http://ors.dhr.georgia.gov/portal/site/DHR-ORS>

All Medicare patients may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's web page at: <http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>
1-800-MED-ICARE

CONSULTATION

The patient, at his/her own request and expense, has the right to consult with a specialist.

PATIENT RESPONSIBILITIES

You are responsible for:

- Providing accurate complete information regarding your present health status (including past and present prescription, herbal, over the counter and supplement medications), past medical history, & for reporting any unexpected changes to the appropriate practitioner (s).
- Following the treatment plan recommended by the primary practitioner.
- Following the rules & regulations of the facility affecting patient care & conduct.
- In the case of a pediatric patient, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.
- Be considerate & respectful of the rights of other patients & facility personnel.
- Providing a responsible adult to transport you home after surgery & an adult to be responsible for you at home for the first 24 hours after surgery/anesthesia.
- Indicating whether you clearly understand a contemplated course of action & what is expected of you.
- Your actions if you refuse treatment, leave the facility against the advice of the practitioner and/or do not follow the practitioner's instructions relating to care.
- Assuring financial obligations of your health care are fulfilled as expediently as possible.

PRIVACY AND CONFIDENTIALITY

The ENT Surgery Center of Augusta complies with federal HIPAA (Health Insurance Portability & Accountability Act) regulations to maintain the privacy of your health information.

ADVANCE DIRECTIVES AND LIMITATIONS

The ENT Surgery Center of Augusta is not an acute care facility; therefore it is our policy to honor an advance directive with the exception of the Do Not Resuscitate (DNR) portion of the advance directive as permitted by Georgia State Statutory law [O.C.G.A. § 31-32-8(2) and O.C.G.A. § 31-32-9(d) (1-2)]. We will adhere to this policy that any physician performing any type of procedure at the Center should not effectuate the DNR order portion of an advance directive. Appropriate emergency procedures will be undertaken to resuscitate patients and transfer them to appropriate facilities in the event of deterioration. Your agreement with this policy **does not** revoke or invalidate any current health care directives or health care power of attorney. If you have an Advance Directive, it is your responsibility to provide a copy to our center on the day of your procedure. Should you be taken to the hospital your copy will go with you. If you would like an Advance Directive you may request one from the front desk of the surgery center.

DISCLOSURE OF OWNERSHIP

The ENT Surgery Center of Augusta is an LLC, owned wholly by the physicians of Augusta ENT, PC, under Georgia State law as a single specialty ambulatory surgery center, Permit 036-286. The physician owners are Drs. Ayers, Barfield, Deal, Kimbrough, Lindman, Owen, Porubsky, Rutledge, Vickery, Wells, White, and Whitehouse.

Revised 04/06/2020

ENT SURGERY CENTER OF AUGUSTA LAB RELEASE FORM

Patient Name:
Date of Surgery:

ENT Surgery Center of Augusta uses University Hospital for specimens and blood work. If this lab does not comply with your insurance company please check the lab of your choice at the bottom of this form and your labs will be sent there. If you fail to choose a specific lab, your laboratory tests will be sent to University Hospital.

PAYMENT POLICY: I understand that it is my responsibility to inform the ENT Surgery Center of Augusta of the lab that my insurance company covers. I also understand that I am personally responsible for payment of all charges, which are incurred for services rendered to me or the above name regardless of insurance coverage.

Select ALL labs within your insurance network

- | | |
|--|--|
| <input type="checkbox"/> South Path | <input type="checkbox"/> Doctors Hospital |
| <input type="checkbox"/> University Hospital Lab | <input type="checkbox"/> Lab Corp |
| <input type="checkbox"/> Quest | <input type="checkbox"/> Clinical Laboratories Southeast |

SIGNATURE _____ DATE _____

ENT SURGERY CENTER OF AUGUSTA

PRE-OP INSTRUCTIONS

Please read these instructions and be sure to follow them carefully to avoid cancellation of your surgery:

If you have any questions feel free to call our office at 706-868-5676. Our surgery center is located at our Evans office, 340 North Belair Rd., in the back of the building.

- 1. Make arrangements to have a responsible adult be with you to drive you home after surgery. You must have an adult stay with you for the first 24 hours after your surgery. A parent or legal guardian must accompany a minor.
- 2. A nurse from the surgery center will contact you the day before surgery for your arrival time. For the safety of our employees, the door of the surgery center will not be unlocked until 6:30 am. Due to limited space, please limit family to two (2) people.
- 3. Do not eat anything (not even candy, gum, or mints) for at least eight (8) hours before your arrival time at the surgery center. You may have clear liquids (water, apple juice, Gatorade/pedialyte, tea or black coffee) up to three (3) hours before your scheduled time of arrival.
- 4. If you routinely take prescription medications, you may do so until three (3) hours prior to your arrival time, unless you have been directed otherwise by your surgeon or anesthesiologist.
- 5. Do not wear any make-up, nail polish, hairpins or jewelry to the surgery center. Do not bring money or valuables.
- 6. Shower or bathe the night before or the morning of surgery. Do not use lotions or oils on the skin the night before or the morning of surgery. Deodorant is permitted.
- 7. Notify the surgeon of any change in your physical condition (fever, cold, sore throat, etc.) before the surgery.
- 8. Wear loose comfortable clothing and shoes that slip on easily. No jeans, pantyhose, high heels or boots. Do not wear contact lenses.
- 9. Please do not take any aspirin products (Advil, Motrin, Aleve, Goody powders, etc.) as well as herbs and vitamins two (2) weeks prior to your surgery date.
- 10. An anesthesiologist will talk to you on the day of your surgery and answer any questions you may have regarding anesthesia.
- 11. Please bring a bottle or sippy cup for infants or small children for use after surgery.
- 12. Please call your insurance company to find out the laboratory they use and please bring your insurance card with you on the day of surgery.

FAILURE TO FOLLOW THE ABOVE INSTRUCTIONS WILL RESULT IN THE CANCELLATION OF YOUR SURGERY.

SIGNATURE OF PATIENT/ LEGAL GUARDIAN

DATE / TIME

SIGNATURE OF NURSE

ENT SURGERY CENTER OF AUGUSTA MEDICATION RECONCILIATION FORM

(Patient to complete shaded portion)

Allergies: ☐ No Known Allergies ☐ See attached list for extensive allergies

Allergy/Reaction: 1 _____

2 _____ 3 _____

4 _____ 5 _____

6 _____ 7 _____

Patient Label

Medication Information Obtained From:

☐ Patient ☐ Family ☐ Written List

CURRENT HOME MEDICATION LIST TO BE COMPLETED BY PATIENT PRE-OPERATIVELY

(Including: Prescription, Over the counter, Herbal Remedies, Vitamins, Dietary Supplements)

TO BE COMPLETED BY PHYSICIAN ON DAY OF SURGERY

Medication	Reason	Dose	Route: oral inject, patch drops	Frequency	Last dose Date/Time	Continue After Discharge		Check with Prescribing Physician
						<input type="checkbox"/> Yes	<input type="checkbox"/> No resume on _____	<input type="checkbox"/>
						<input type="checkbox"/> Yes	<input type="checkbox"/> No resume on _____	<input type="checkbox"/>
						<input type="checkbox"/> Yes	<input type="checkbox"/> No resume on _____	<input type="checkbox"/>
						<input type="checkbox"/> Yes	<input type="checkbox"/> No resume on _____	<input type="checkbox"/>
						<input type="checkbox"/> Yes	<input type="checkbox"/> No resume on _____	<input type="checkbox"/>
						<input type="checkbox"/> Yes	<input type="checkbox"/> No resume on _____	<input type="checkbox"/>
						<input type="checkbox"/> Yes	<input type="checkbox"/> No resume on _____	<input type="checkbox"/>
						<input type="checkbox"/> Yes	<input type="checkbox"/> No resume on _____	<input type="checkbox"/>
						<input type="checkbox"/> Yes	<input type="checkbox"/> No resume on _____	<input type="checkbox"/>
						<input type="checkbox"/> Yes	<input type="checkbox"/> No resume on _____	<input type="checkbox"/>

Patient Acknowledgement:

I have provided as accurate a list as I can of my home medications. I will continue to follow the medication orders of the prescribing physician unless instructed to change. If I have any questions about my home medications, I will call the doctor prescribing them.

Patient (designee) signature: _____ Date: _____

NEW/CHANGED MEDICATION TO BE TAKEN UPON DISCHARGE: ☐ N/A

Medication	Dose	Frequency	Route	Other Instructions

ADMISSION

DISCHARGE

☐ List reviewed with patient

RN Signature Date/Time

RN Signature Date/Time Responsible Party Date/Time

Physician Signature Date/Time

ENT SURGERY CENTER OF AUGUSTA
ANESTHESIA HISTORY & PHYSICAL ASSESSMENT

HOME PHONE: _____

Patient Label

ALTERNATIVE #: _____

HEIGHT: _____ **WEIGHT:** _____ **AGE:** _____

RACE*: ☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ Pacific Islander ☐ White ☐ Multi-Racial

ALLERGIES: _____

TYPE OF REACTION: _____

SCHEDULED PROCEDURE: _____ **DATE:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

PHONE #: _____

WHO WILL BE WITH YOU THE DAY OF SURGERY: _____

LIST ALL MEDICATIONS & STRENGTHS YOU TAKE DAILY:

(INCLUDE EYE DROPS, INHALERS, VITAMINS, HERBAL SUPPLEMENTS, ASPIRIN, AND BIRTH CONTROL PILLS)

DRUG AND STRENGTH

LAST TAKEN

REASON FOR TAKING

LIST ALL SURGERIES AND DATES:

SURGERY

DATE

ARE YOU CURRENTLY EXPERIENCING ANY PAIN? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

--

DATE OF LAST X-RAY: _____ NORMAL _____ ABNORMAL _____

DATE OF LAST EKG: _____ NORMAL _____ ABNORMAL _____

NAME OF YOUR FAMILY PHYSICIAN: _____ TELEPHONE # _____

* Requested by State of Georgia Department of Community Health

(CONTINUED ON BACK)

PLEASE CHECK ONE OF THE FOLLOWING: (PATIENT INFORMATION ONLY)

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Any problems with prior anesthetics? If yes, please describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you ever had fever after an anesthetic? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has any family member had problems with anesthetics, including malignant hyperthermia, paralysis, etc.? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you smoke? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you drink alcohol? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you use any recreation drugs, including heroin, cocaine, marijuana, etc? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you allergic to latex? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you taken steroids over the past year? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Can you climb 2 flights of stairs nonstop without getting chest pain or shortness of breath? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you exercise? Type/how often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had a blood transfusion? If yes, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Could you be pregnant?
What is the date of your last menstrual period? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you have any bleeding or clotting abnormalities including easy bruising or excessive vaginal bleeding? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have any implants? If yes, what type? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you had any recent colds? If yes, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you have loose teeth, chipped teeth, dentures, caps, crowns, bridgework, braces?
If yes, please list. _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you have difficulty or pain with opening your mouth widely or tilting your head back to look above you? |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Do you wear contact lenses or glasses? |

DO YOU HAVE ANY OF THE FOLLOWING?

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Thyroid or goiter problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Diabetes or epilepsy? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Muscle weakness, paralysis, stroke? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. High blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Chest pain, angina? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Heart disease, murmur, mitral valve prolapse? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Lung disease, shortness of breath, chronic cough? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Asthma, wheezing? Last attack: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Kidney or bladder disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Hepatitis, jaundice, cirrhosis, HIV positive? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Ulcers? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Hiatal hernia or reflux? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Anemia or recent weight loss? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Have you ever had nose or jaw surgery? |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you had any broken facial bones? |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Frequent headaches or dizzy spells? |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Any back problems, including surgeries, fractures, painful positions. |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Motion sickness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you ever taken Redux, Phen-Phen, or any other diet pill? Date _____ |

Patient/Responsible Party Signature _____ **Date** _____

Assessment reviewed, positive findings were discussed with patient/family.

Anesthesiologist's Signature: _____ Date: _____



ENT Surgery Center of Augusta
706-868-5676





PARENTS/GUARDIANS

PLEASE READ BEFORE THE DAY OF PROCEDURE

Eating or drinking rules before your child's surgery

Food and drink taken before anesthesia can cause problems such as choking or vomiting.

If you don't follow these rules, your child's surgery may be canceled.

Type of Food	Examples	Latest time you can eat or drink
Clear liquids 	<u>Liquids you can see through</u> such as water, apple juice, Pedialyte, other clear juices without pulp, plain jello	3 hours before you are told to arrive at the Surgery Center
Breast Milk		4 hours before you are told to arrive at the Surgery Center
ALL other foods and liquids 	Solids, milk, formula, candy, meat, bread, fried foods, cheeses, ice cream, mints or gum.	Up until midnight the night before surgery

You will receive more specific eating and drinking instructions, as well as, instructions regarding any prescribed medications from our preoperative nurse the day before your surgery.



Call if you have any questions,
The Preoperative Evaluation Center
706-868-5676 ext. 756
Monday-Friday 9 AM-5 PM



Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, **ENT Surgery Center of Augusta, LLC** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand and have been provided with a *Notice of Privacy Policies* that provides a complete description of information uses and disclosures in addition to my rights. I understand that **ENT Surgery Center of Augusta, LLC** is not required to agree to any restrictions requested by me. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that **ENT Surgery Center of Augusta, LLC** reserves any right to change their notice in accordance with Section 164.520 of the Code of Federal Regulations. Should **ENT Surgery Center of Augusta, LLC** change their notice an updated copy will be available upon my next visit to the practice and/or I may request a copy be sent to my address. I also may visit the office at any time to obtain a current copy of the practice's *Notice*.

I wish to have the following restrictions to the use or disclosure of my health information: _____

I wish to allow the following individuals access to my medical records, medical information, billing and payment information with ENT Surgery Center of Augusta, LLC: _____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Please initial by each form of communication by which we can contact the patient.

_____ ENT Surgery Center of Augusta, LLC may **call** my home at the following number and leave the appointment date and time on my telephone answering machine, voicemail, or with whomever answers my phone if I am not available. I understand that other individuals may have access to the information left by this method. I understand that no other information will be provided in granting permission to leave the date and time.

Telephone Number on which messages can be left: _____

_____ ENT Surgery Center of Augusta, LLC may **email** my home or other email address any information that will assist ENT Surgery Center of Augusta with the treatment, payment, and health care operations for the patient. This can include appointment reminders, statements, insurance information, and any information concerning my clinical care.

Email address to which information can be sent: _____

_____ ENT Surgery Center of Augusta, LLC may send a **text message** to my cellular phone regarding appointment reminders, cancellations, or time changes. This form of communication will be for the use of the Appointment Desk and not private or clinical information.

Cell Phone to which information may be texted: _____

***** I fully understand and (circle one) [accept / decline] the terms of this consent. *****

Patient/Legal Guardian Signature Date Practice Representative Date

FOR OFFICE USE ONLY

[] Consent received by _____ on _____
[] Consent refused by patient, and treatment refused as permitted. _____
[] Notice provided to patient. Consent form not signed due to: _____
Action to be taken: _____

Statement of Nondiscrimination

The ENT Surgery Center of Augusta complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The ENT Surgery Center of Augusta does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The ENT Surgery Center of Augusta provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

The ENT Surgery Center of Augusta also provide free aids and services to help people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats and more)

If you need these services for your surgical procedure, please tell the nurse during your preoperative interview or call **706-364-4040**.

If you believe that the ENT Surgery Center of Augusta has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Keith Lynn
Civil Rights Coordinator
340 N. Belair Rd
Evans, GA 30809
Phone: 706-868-5676
Fax: 706-922-4385

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, a patient representative will help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights complaint portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019

1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Statements of Nondiscrimination in Languages Used in Georgia

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 706-364-4040.

Spanish

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de interpretación. Comuníquese con alguien del personal de registros o llame al 706-364-4040.

Vietnamese

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin liên lạc với nhân viên phụ trách ghi danh hay gọi số 706-364-4040.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 706-364-4040 번으로 전화해 주십시오.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 706-364-4040

Gujarati

ચના: જો તમે જરાતી બોલતા હો, તો િન: લુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 706-364-4040

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 706-364-4040

Amharic

ማሳሰቢያ: -አማርኛ ተናጋሪ ከሆኑ፣ ከግብርና ሆስፒታል ውስጥ የሚገኙትን ብሔራዊ ብሔራዊ አገልግሎቶች ለአርሲ ዘመድ ማግኘት ይቻላል፡፡ ከምሳሌ ለሰራተኞች ውስጥ አንዱ ቸውን ያነጋግሩ ወይም በስልክ ቁጥር 706-364-4040 ይደውሉ፡፡

Hindi

ध्यान दें: यदि आप हिंदी बोलते तो आपके ललए मुफ्त में भाषा सिं यता सेवाएं उपलब्ध ह। 706-364-4040 पर फोन करें।

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 706-364-4040

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 706-364-4040

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم هاتف الصم والبكم: 4040-364-706

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 706-364-4040

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 706-364-4040 تماس بگیرید.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich an das Anmeldepersonal oder wählen Sie die Rufnummer 706-364-4040

Japanese

注意事項：日本語での言語サポートを無料で提供しています。レジストレーション・スタッフ、または 706-364-4040 までお問い合わせください。