

Mission:
To protect, promote & improve the health
of all people in Florida through integrated
state, county & community efforts.



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

FLORIDA CONRAD 30/J-1 VISA WAIVER PROGRAM APPLICATION

Only typed applications will be accepted. File save this pdf to your computer for typing and final saving.

<input type="checkbox"/> Primary Care	<input type="checkbox"/> Specialist	<input type="checkbox"/> FLEX	DOB:	USDOS Case #:
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<u>I. Physician Information:</u>		
Name, Last:	First:	Middle:
Email Address:	FL License Number:	
Country of Birth:	Country of Residence:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Practice Specialty (select one):		
<input type="checkbox"/> Primary Care-Family Medicine	<input type="checkbox"/> Primary Care-Internal Medicine	<input type="checkbox"/> Primary Care-Pediatrics
<input type="checkbox"/> Primary Care-OB/GYN	<input type="checkbox"/> Primary Care-Psychiatry	<input type="checkbox"/> Primary Care-Hospitalist
<input type="checkbox"/> Specialist (specify):	Subspecialty (if applicable):	
Did you complete your residency in the state of Florida? <input type="checkbox"/> Yes <input type="checkbox"/> No (specify state):		
Does your employment contract contain a non-compete clause? <input type="checkbox"/> Yes <input type="checkbox"/> No		

<u>II. Employer Information:</u>		
Employer Name:		
Email Address:	Telephone Number:	
Address:		
City:	Zip:	County:
Employer Type:		
<input type="checkbox"/> For Profit <input type="checkbox"/> Non-Profit <input type="checkbox"/> Safety Net Provider (specify):		
Service Type:		
<input type="checkbox"/> Outpatient/Ambulatory <input type="checkbox"/> Hospitalist <input type="checkbox"/> Other (specify):		
Primary Practice Facility of J-1 Physician:		
Facility Name:	Address:	
City:	Zip:	County:
Secondary Practice Facility of J-1 Physician (if applicable):		
Facility Name:	Address:	
City:	Zip:	County:
Tertiary Practice Facility of J-1 Physician (if applicable):		
Facility Name:	Address:	
City:	Zip:	County:

FLORIDA CONRAD 30/J-1 VISA WAIVER

RECOMMENDATION APPLICATION

III. Patient Information: Provide the total number of active patients at the primary practice site in the previous calendar year with totals, as applicable, for primary care, specialty care, and mental health services. Then provide a breakdown (percentage) of each of the following payer types by patient group for the previous calendar year.

<i>Primary Care</i>	<i>Specialty Care</i>	<i>Mental Health Care</i>	<i>Total</i>

	<i>Sliding Fee</i>	<i>Medicaid</i>	<i>Medicare</i>
<i>Pediatric/Adolescent</i>	%	%	
<i>Adult</i>	%	%	%

IV. Specialist and FLEX Waiver Addendums:

Applicants submitting an application for a specialist waiver must demonstrate a need by addressing the following:

- 1) Describe how the physician’s employment will satisfy important unmet needs of the medical practice patients and the specific health care needs of the community served.
- 2) Describe how the physician’s performance competencies or specific training and skills will meet the needs of the patient population and community to be served.
- 3) Describe the underserved population to be served; example: health status issues, health access issues.
- 4) Provide the number of physicians practicing this specialty in the service area. If this specialty is currently not available in the service area, identify the nearest location where this specialty service can be obtained.

Applicants submitting an application for a FLEX waiver must demonstrate a need by addressing the following:

- 1) Describe the facility’s service area. Provide evidence that a minimum of 30% of the employer’s current patient base resides in a neighboring HPSA or MUA/P (for example, a patient visit report that identifies total patient visits in the last 6-12 months of service by patient origin zip code).
- 2) Describe who will benefit from the physician’s services. Identify the percent of Medicaid and sliding fee scale patients who will have access to this physician. Describe how the facility will assure access to this physician for low-income or uninsured patients.
- 3) Provide evidence the facility serves a disproportionate share of uninsured or Medicaid recipients (include data on the number of patients affected and how many are low-income or uninsured). Include a copy of sliding fee scale and notice of such as provided to patients in site waiting room.
- 4) If this service is not currently available in the community, identify the nearest location where this service can be obtained.

V. Assurances

I hereby acknowledge that all information and statements contained herein are true and do not misrepresent fact. I further acknowledge that I have not evaded or suppressed any information contained in this application or in any of the supporting materials.

J-1 Physician Signature

Date

J-1 Physician Printed Name

Employer Signature

Date

Employer Printed Name

Title

Attorney Contact Information (If Applicable):

Name: _____ Email: _____

**FLORIDA CONRAD 30 J1 VISA WAIVER PROGRAM
CERTIFICATION STATEMENT A
AFFIDAVIT AND AGREEMENT: CONRAD 30 REQUIREMENTS**

BEFORE ME, the undersigned authority, personally appeared _____,
who after being duly sworn deposes:

1. I, _____, have requested the Florida Department of Health (FDOH) to review my application for a waiver of the foreign residency requirement set forth in my visa. By this review, I am requesting that the FDOH recommend the U.S. Citizenship and Immigration Service (USCIS) approve such a waiver of the residency requirement. I understand and acknowledge that the review of this request is discretionary and that in the event a decision is made not to recommend the waiver, I hold the State of Florida, FDOH, its employees, or any and all individuals or organizations involved in the review process harmless from any action or lack of action made in connection with this request.
2. I understand and acknowledge that a FDOH recommendation to grant this request does not guarantee approval from the U.S. Department of State or the USCIS.
3. I further understand and acknowledge that the entire basis for the consideration of my request is FDOH's voluntary participation and mission to increase the availability of medical care in areas designated by the Secretary of the U.S. Department of Health and Human Services (USHHS) as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps).
4. I understand and agree that in consideration for the granting of a waiver by the USCIS, I shall render medical care services to patients, including the underserved, for a minimum of 40 hours per week within a designated HPSA or MUA/P in Florida. Such service shall commence not later than 90 days after I receive notification of approval by the USCIS and shall continue for a minimum of three years.
5. I agree to provide health services to individuals without discriminating against them because (a) they are unable to pay for those services or (b) payment for those health services will be made under Medicaid or Medicare. I will charge persons receiving services at the usual and customary rate prevailing in the HPSA or MUA/P in which services are provided, except persons at or below 200 percent of the federal poverty level as determined annually by the USHHS. All persons shall be charged on a sliding fee scale or shall not be charged if they are unable to pay for these services.
6. I expressly agree to provide written notification of the specific location and nature of my practice to FDOH at the time I receive notification of the granting of the waiver from USCIS and at the time I commence rendering services in the HPSA or MUA/P. I further understand and agree that relocation from a site approved in the application request to a different site must be approved by FDOH in writing prior to the relocation.
7. I agree to comply with the requirements set forth in Section 214 of the Immigration and Naturalization Act and to comply with all FDOH visa waiver program monitoring and reporting requirements.
8. I further certify that my prospective employer will structure my employment and the operations of the health care facility to facilitate my compliance with the requirements of my waiver, if granted.

I declare under the penalties of perjury that the foregoing is true and correct.

Date

Printed Name of Physician

Signature of Physician

Sworn to and subscribed before me this _____ day of _____.

Signature of Notary Public

My commission expires: _____/_____/_____

**FLORIDA CONRAD 30 J1 VISA WAIVER PROGRAM
CERTIFICATION STATEMENT B
AFFIDAVIT AND AGREEMENT
CONRAD 30 APPLICATION IS EXCLUSIVELY TO THE FLORIDA DEPARTMENT OF
HEALTH**

BEFORE ME, the undersigned authority, personally appeared _____,
who after being duly sworn deposes:

I, _____, hereby declare and certify, under penalty of the provisions of 18 USC.1001, that: (1) I have sought or obtained the cooperation of the Florida Department of Health which is submitting an IGA request on behalf of me under the Conrad 30 Program to obtain a waiver of the two-year home residency requirement; and (2) I do not now have pending nor will I submit during the pendency of this request, another request to any U.S. Government department or agency or any equivalent, to act on my behalf in any matter relating to a waiver of my two-year home residence requirement.

I declare under the penalties of perjury that the foregoing is true and correct.

Date

Printed Name of Physician

Signature of Physician

Sworn to and subscribed before me this _____ day of _____.

Signature of Notary Public

My commission expires: _____/_____/_____

**FLORIDA CONRAD 30 J1 VISA WAIVER PROGRAM
CERTIFICATION STATEMENT C
HPSA –MUA Practice Location Affidavit**

BEFORE ME, the undersigned authority, personally appeared _____,
who after being duly sworn deposes:

I, _____, of _____,
(Name of employer) *(Name of facility)*

hereby certify, under penalty of the provisions of 18 U.S.C. 1001, that: (1) our facility is located
at _____;
(Full physical address, county, FIPS code, census tract)

(2) is located in a medical shortage area (_____); and
(HPSA or MUA/P ID Number)

(3) provides medical care to Medicare and Medicaid eligible patients and indigent, uninsured
patients.

I declare under the penalties of perjury that the foregoing is true and correct.

Date

Printed Name

Signature

Sworn to and subscribed before me this _____ day of _____.

Signature of Notary Public

My commission expires: _____ / _____ / _____

**FLORIDA CONRAD 30/J-1 VISA WAIVER PROGRAM
GUIDELINES AND PROCEDURES**

Application Checklist:

- 1) Florida Conrad 30 Recommendation Application
- 2) Certification Statement A (Affidavit and Agreement Form)
- 3) Certification Statement B (Physician Attestation)
- 4) Certification Statement C (Employer Attestation)
- 5) Specialist or FLEX waiver addendum (if applicable)
- 6) Practice facility's cover letter
- 7) Employment Contract
- 8) Evidence of shortage designation status
- 9) Facility's sliding fee scale
- 10) Photo of the sliding fee scale public notice
- 11) Physician's Florida medical license or license application
- 12) Physician's Curriculum Vitae
- 13) Physician's Personal Statement
- 14) Form DS-3035
- 15) DS-2019/IAP-66 forms
- 16) Form I-94 entry and departure cards
- 17) Explanation for Out of Status (if applicable)
- 18) Form G-28 or letterhead from law office (if applicable)
- 19) "No Objection" Statement (if applicable)

**Applications must be submitted by USPS mail, Fed Ex, United Parcel Service or a similar mail carrier service to: State Primary Care Office
Division of Public Health Statistics and Performance Management
Florida Department of Health
4052 Bald Cypress Way, Bin #A05
Tallahassee, Florida 32399**

Additional Resources and Links:

For additional information and supporting documents for Florida's visa waiver programs, visit the Florida Department of Health State Primary Care Office website:

<http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/conrad-30-program-j-1-visa/>

For information regarding the J-1 Visa, visit the USDOS J-1 Visa website:

<http://j1visa.state.gov/programs/physician/>

For information regarding the USDOS application instructions, visit the USDOS website:

<http://travel.state.gov/content/visas/english/study-exchange/student/residency-waiver/ds-3035-instructions.html>

For information regarding health professional shortage areas, visit the Health Resources and Services Administration (HRSA) website:

<http://www.hrsa.gov/shortage/>

For information regarding sliding fee scales, visit the HRSA website:

<http://bphc.hrsa.gov/technicalassistance/taresources/slidingrequirements.html>

For information regarding federal poverty guidelines, visit the U.S. Department of Human Services Office of The Assistant Secretary for Planning and Evaluation website:

<http://aspe.hhs.gov/poverty/index.cfm>

For information regarding employment opportunities in Florida, visit the National Rural Recruitment and Retention Network (3RNet) website:

<https://www.3rnet.org/locations/florida>