



**CONRAD 30/J-1 VISA WAIVER PROGRAM**  
**Florida Department of Health Sponsorship**

*Only typed applications will be accepted.*

**I. Physician Information:**

Name: Last:	First:	Middle:
Country of Last Legal Permanent Residence:		
Applicant email:		Attorney email:

**II. Employer Information:**

Employer Name:			
Address:			
City:	State:	Zip:	County:

**III. Practice Site Information:**

<b>Primary Practice Site Location of J-1 Physician</b>			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	Zip:	County:
<input type="checkbox"/> HPSA	<input type="checkbox"/> MUA	<input type="checkbox"/> MUP	HPSA/MUA/MUP ID Number:

<b>Secondary Practice Site Location of J-1 Physician</b>			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	Zip:	County:
<input type="checkbox"/> HPSA	<input type="checkbox"/> MUA	<input type="checkbox"/> MUP	HPSA/MUA/MUP ID Number:

<b>Tertiary Practice Site Location of J-1 Physician</b>			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	Zip:	County:
<input type="checkbox"/> HPSA	<input type="checkbox"/> MUA	<input type="checkbox"/> MUP	HPSA/MUA/MUP ID Number:

*Additional Site Locations may be submitted on separate sheet. All location information must be included.*

**IV. 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

USDOS Case #: