



**National Interest Waiver  
Florida DOH Sponsorship Application**  
*Only typed applications will be accepted.*

**I. Physician Information:**

Name: Last:	First:	Middle:
Email Address:	FL Medical License Number*:	
Country of Birth:	Country of Legal Permanent Residence:	
DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	* If you have recently applied for your Florida license, please enter the Initial Application ID issued by the DOH.
Practice Type (select only one):		
<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Internal Medicine (enter subspecialty below)	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Obstetrics/Gynecology	<input type="checkbox"/> Psychiatry	
<input type="checkbox"/> Specialist (specify):	Subspecialty (if applicable):	
Did you complete your residency program in the state of Florida? <input type="checkbox"/> Yes <input type="checkbox"/> No (specify state):		

**II. Employer Information:**

Employer Name:			
Address:			
City:	State:	Zip:	County:
Contact Name:		Telephone Number:	
Email Address:			
Employer Type:	<input type="checkbox"/> For Profit	<input type="checkbox"/> Non-Profit	<input type="checkbox"/> Safety Net Provider

**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:
Contact Name:		Contact Phone:	
<input type="checkbox"/> HPSA [Score: ]	<input type="checkbox"/> MUA/P	HPSA or MUA/P ID Number:	
Majority of Practice Patients Are: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Other (specify):			

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Secondary Practice Site Location of J-1 Physician			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	Zip:	County:
Contact Name:		Contact Phone:	
<input type="checkbox"/> HPSA [Score: ] <input type="checkbox"/> MUA/P		HPSA or MUA/P ID Number:	
Majority of Practice Patients Are: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Other (specify):			

Tertiary Practice Site Location of J-1 Physician			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	Zip:	County:
Contact Name:		Contact Phone:	
<input type="checkbox"/> HPSA [Score: ] <input type="checkbox"/> MUA/P		HPSA or MUA/P ID Number:	
Majority of Practice Patients Are: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Other (specify):			

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

### III. Patient Information:

Provide the total number of active patients with the employer in the previous calendar year, for the specified types of care. If the primary site location is a subset of the employer's practice, please provide the number of active patients at the primary site.

	Primary Care	Specialty Care	Mental Health Care
<b>Employer</b>			
<b>Primary Site Location</b>			

Provide a breakdown of each payer type by patient group for the employer for the previous calendar year.

	Sliding Fee/ Charity Care	Medicaid (including dual eligibles)	Medicare Only	Private Insurance/Other	Total
<b>Pediatric (&lt;18)</b>	%	%	%	%	%
<b>Adult (&gt;18)</b>	%	%	%	%	%

### 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

\_\_\_\_\_  
J-1 Physician Printed Name

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer Printed Name

\_\_\_\_\_  
Title

Application materials must be submitted electronically to: [FL.PCO@flhealth.gov](mailto:FL.PCO@flhealth.gov)