CONRAD 30/J-1 VISA WAIVER PROGRAM
Florida Department of Health Sponsorship Application
2019-2020

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:

Primary Practice Site Location of J-1 Physician			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	Zip:	County:
☐ HPSA ☐ MUA ☐ MUP ☐ None		HPSA/MUA/MUP ID Number:	

Secondary Practice Site Location of J-1 Physician			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	Zip:	County:
☐ HPSA ☐ MUA ☐ MUP ☐ None		HPSA/MUA/MUP ID Number:	

Tertiary Practice Site Location of J-1 Physician			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	Zip:	County:
☐ HPSA ☐ MUA ☐ MUP ☐ None		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 #: