



## CONRAD 30 VISA WAIVER PROGRAM

*Only typed applications will be accepted.*

Florida DOH Sponsorship Application

USDOS Case #:
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### I. Physician Information

Name: Last:	First:	Middle:
Email Address:		FL Medical License Number*:
Country of Birth:		Country of Legal Permanent Residence:
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	DOB:	Current Residence:
Practice Type ( <b>select only one</b> ):		
<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Internal Medicine - General	<input type="checkbox"/> Pediatrics - General
<input type="checkbox"/> Obstetrics/Gynecology - General	<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):		
Do you plan to remain in the state of Florida after your Conrad 30 employment is over? <input type="checkbox"/> Yes <input type="checkbox"/> No		

\* If you have recently applied for your Florida license, please enter the Initial Application ID issued by the Department of Health.

### II. Employer Information

Employer Name:			
Address:			
City:	State:	ZIP:	County:
Contact Name:		Telephone Number:	
Email Address:			
Employer Type: (choose 1) <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 Physician</b>			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	ZIP:	County:
Contact Name:		Contact Phone:	
HPSA Score:	HPSA Name:	HPSA ID Number:	
Majority of Practice Patients Are: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Other (specify):			

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<b>Secondary Practice Site Location of Physician</b>			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	ZIP:	County:
Contact Name:		Contact Phone:	
HPSA Score:	HPSA Name:	HPSA ID Number:	
Majority of Practice Patients Are: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Other (specify):			

<b>Tertiary Practice Site Location of Physician</b>			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	ZIP:	County:
Contact Name:		Contact Phone:	
HPSA Score:	HPSA Name:	HPSA ID Number:	
Majority of Practice Patients Are: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Other (specify):			

<b>Quaternary Practice Site Location of Physician</b>			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	ZIP:	County:
Contact Name:		Contact Phone:	
HPSA Score:	HPSA Name:	HPSA ID Number:	
Majority of Practice Patients Are: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Other (specify):			

*Additional site locations must be submitted on separate sheet. All location information must be included.*

**III. Patient Information**

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

	<b>Sliding Fee/ Charity Care</b>	<b>Medicaid</b> <i>(including dual eligible)</i>	<b>Medicare Only</b>	<b>Private Insurance/Other</b>	<b>Total</b>
<b>Pediatric (&lt;18)</b>	%	%	N/A	%	%
<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.

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Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Printed Name

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Title

Attorney Contact Information (if applicable):

Name:

Telephone:

Email: