



CONRAD 30 WAIVER PROGRAM
EMPLOYER PRACTICE LOCATION ATTESTATION
Health Professional Shortage Area (HPSA)
Practice Location

(Provide one form for each practice location.)

I, _____, of _____,
hereby certify, under penalty of the provisions of 18 U.S.C. 1001, that:

- (1) our facility/site is located at _____;
- (2) is located in a health professional shortage area (_____); and
- (3) provides medical care regardless of a patient's ability to pay (this includes accepting Medicaid, Children's Health Insurance Program, Medicare and the indigent/uninsured through a sliding fee scale or charity care program).

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

Date

Printed Name of Employer

Signature of Employer

Physician Name: _____ USDOS Case #: _____