



**FLORIDA HHS WAIVER PROGRAM  
AFFIDAVIT AND AGREEMENT FORM**

**BEFORE ME**, the undersigned authority, personally appeared as \_\_\_\_\_,  
Physician Name  
who after being duly sworn deposes:

1. I, \_\_\_\_\_, have requested the Florida Department of Health (FDOH) to review my application for a Health and Human Services Exchange Visitor Program Waiver. By this review, I am requesting that the FDOH recommend the U.S. Citizenship and Immigration Service (USCIS) approve such a waiver. I understand and acknowledge that the review of this request is discretionary and that in the event a decision is made not to recommend the waiver, I hold the State of Florida, FDOH, its employees, or any and all individuals or organizations involved in the review process harmless from any action or lack of action made in connection with this request.
2. I understand and acknowledge that a FDOH recommendation to grant this request does not guarantee approval from the U.S. Department of State (USDOS) or the USCIS.
3. I further understand and acknowledge that the entire basis for the consideration of my request is FDOH's voluntary participation and mission to increase the availability of medical care in areas designated by the Secretary of the U.S. Department of Health and Human Services (USHHS) as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps).
4. I understand and agree that in consideration for the granting of a waiver by the USCIS, I shall render medical care services to patients, including the underserved, for a minimum of 40 hours per week within a designated HPSA or MUA/P in Florida.
5. I agree to provide health services to individuals without discriminating against them because (a) they are unable to pay for those services or (b) payment for those health services will be made under Medicaid or Medicare. I will charge persons receiving services at the usual and customary rate prevailing in the HPSA or MUA/P in which services are provided, except persons at or below 200 percent of the federal poverty level as determined annually by the USHHS. All persons shall be charged on a sliding fee scale or shall not be charged if they are unable to pay for these services.
6. I understand and agree that relocation from a site approved in the application request to a different site must be approved by FDOH in writing prior to the relocation.
7. I agree to comply with all FDOH visa waiver program monitoring and reporting requirements.
8. I further certify that my prospective employer will structure my employment and the operations of the health care facility to facilitate my compliance with the requirements of my waiver, if granted.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Signature of Physician

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public

My commission expires: \_\_\_\_\_