FLORIDA HHS EXCHANGE VISITOR PROGRAM
Application for Letter of Support

PLEASE TYPE OR PRINT CLEARLY

I. Physician Information:

Name, Last: First: Middle:

Email Address: FL License Number:

Country of Birth: Country of Residence:

Date of Birth: Gender: ☐ Female ☐ Male

Practice Specialty (select one):
☐ Family Medicine ☐ Internal Medicine ☐ Pediatrics ☐ OB/GYN ☐ Psychiatry
Subspecialty (if applicable):

II. Employer Information:

Employer Name:

Email Address: Telephone Number:

Address:

City: Zip: County:

Primary Practice Facility:
Facility Name: Address:
City: Zip: County:

Secondary Practice Facility (if applicable):
Facility Name: Address:
City: Zip: County:

Tertiary Practice Facility (if applicable):
Facility Name: Address:
City: Zip: County:

III. 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.

_____	_____
Physician Signature	Date
_____	
Physician Printed Name	
_____	_____
Employer Signature	Date
_____	_____
Employer Printed Name	Title

Application materials may be submitted electronically to: FL.PCO@flhealth.gov

Or by mail to:

Application materials may be mailed to:
State Primary Care Office
Division of Public Health Statistics and Performance Management
Florida Department of Health
4052 Bald Cypress Way, Bin #A05
Tallahassee, Florida 32399