

HHS EXCHANGE VISITOR PROGRAM LETTER OF SUPPORT REQUEST FORM



PLEASE TYPE OR PRINT CLEARLY

<u>I. Physician Information:</u>		
Name, Last:	First:	Middle:
Email Address:	FL License Number:	
Home Country:	Country of Birth:	
Date of Birth:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Practice Specialty (select one):		
<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Psychiatry	
Subspecialty (if applicable):		
Did you complete your residency in the state of Florida?		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, which state?
<u>II. Employer Information:</u>		
Employer Name:		
Email Address:	Telephone Number:	
Address:		
City:	County:	Zip:
Employer Type (select one):		
<input type="checkbox"/> Health center as defined under Section 330 of the Public Health Service Act, and which is receiving a grant from the U.S. Health Resources and Services Administration under this section		
<input type="checkbox"/> Rural health clinic as defined under Sections 1102 and 1871 of the Social Security Act		
<input type="checkbox"/> Native American/Alaskan Native tribal medical facility as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638)		
Primary Practice Facility:		
Facility Name:	Address:	
City:	County:	Zip:
Secondary Practice Facility (if applicable):		
Facility Name:	Address:	
City:	County:	Zip:
Tertiary Practice Facility (if applicable):		
Facility Name:	Address:	
City:	County:	Zip:

III. Sliding Fee Schedule Information:

Does the health care facility have an existing discounted/sliding fee schedule? Yes No

If yes, does the facility have a notice conspicuously posted of the availability of the discounted/sliding fee schedule? Yes No

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.

Physician Signature

Date

Physician Printed Name

Employer Signature

Date

Employer Printed Name

Title