



**National Interest Waiver
Florida DOH Sponsorship Application**
Only typed applications will be accepted.

I. Physician Information:

Name: Last:		First:		Middle:	
Email Address:			FL Medical License Number*:		
Country of Birth:			Country of Legal Permanent Residence:		
DOB:		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		* If you have recently applied for your Florida license, please enter the Initial Application ID issued by the DOH.	
Practice Type (select only one):					
<input type="checkbox"/> Family Medicine		<input type="checkbox"/> Internal Medicine (enter subspecialty below)		<input type="checkbox"/> Pediatrics	
<input type="checkbox"/> Obstetrics/Gynecology		<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):					

II. Employer Information:

Employer Name:			
Address:			
City:	State:	Zip:	County:
Contact Name:		Telephone Number:	
Email Address:			
Employer Type:	<input type="checkbox"/> For Profit	<input type="checkbox"/> Non-Profit	<input type="checkbox"/> Safety Net Provider

III. Practice Site Information:

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

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

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

Additional Site Locations may be submitted on separate sheet. All location information must be included.

III. Patient Information:

Provide the total number of active patients with the employer in the previous calendar year, for the specified types of care. If the primary site location is a subset of the employer's practice, please provide the number of active patients at the primary site.

	Primary Care	Specialty Care	Mental Health Care
Employer			
Primary Site Location			

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

	Sliding Fee/ Charity Care	Medicaid (including dual eligibles)	Medicare Only	Private Insurance/Other	Total
Pediatric (<18)	%	%	%	%	%
Adult (>18)	%	%	%	%	%

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.

J-1 Physician Signature

Date

J-1 Physician Printed Name

Employer Signature

Date

Employer Printed Name

Title

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