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: ☐ Female ☐ 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)**:		
☐ Family Medicine	☐ Internal Medicine (enter subspecialty below)	☐ Pediatrics
☐ Obstetrics/Gynecology	☐ Psychiatry	
☐ Specialist (specify):	Subspecialty (if applicable):	
Did you complete your residency program in the state of Florida? ☐ Yes ☐ No (specify state):		

II. Employer Information:

Employer Name:			
Address:			
City:	State:	Zip:	County:
Contact Name:		Telephone Number:	
Email Address:			
Employer Type:	☐ For Profit	☐ Non-Profit	☐ 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:	
☐ HPSA [Score:] ☐ MUA/P		HPSA or MUA/P ID Number:	
Majority of Practice Patients Are:	☐ Outpatient	☐ Inpatient	☐ Other (specify):

Secondary Practice Site Location of Physician			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	Zip:	County:
Contact Name:		Contact Phone:	
☐ HPSA [Score:] ☐ MUA/P		HPSA or MUA/P ID Number:	
Majority of Practice Patients Are: ☐ Outpatient		☐ Inpatient	☐ 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:	
☐ HPSA [Score:] ☐ MUA/P		HPSA or MUA/P ID Number:	
Majority of Practice Patients Are: ☐ Outpatient		☐ Inpatient	☐ 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.

Physician Signature _____ Date _____

Physician Printed Name _____

Employer Signature _____ Date _____

Employer Printed Name _____ Title _____

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