



FLORIDA VISA WAIVER PHYSICIAN PRACTICE STATUS REPORT

PLEASE TYPE OR PRINT CLEARLY

<input type="checkbox"/> Conrad 30	<input type="checkbox"/> NIW	<input type="checkbox"/> HHS Waiver	Report Completion Date:
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<u>I. Physician Information:</u>			
Name, Last:	First:	Middle:	
Email Address:	FL License Number:		
Practice Specialty (select one):			
<input type="checkbox"/> Primary Care-Family Medicine	<input type="checkbox"/> Primary Care-Internal Medicine	<input type="checkbox"/> Primary Care-Pediatrics	
<input type="checkbox"/> Primary Care-OB/GYN	<input type="checkbox"/> Primary Care-Psychiatry	<input type="checkbox"/> Primary Care-Hospitalist	
<input type="checkbox"/> Specialist (specify):	Subspecialty (if applicable):		
Employment Start Date:	Employment End Date:		
Employment Status (select one):			
<input type="checkbox"/> Year 1	<input type="checkbox"/> Year 2	<input type="checkbox"/> Year 3	<input type="checkbox"/> Year 4 (NIW) <input type="checkbox"/> Year 5 (NIW)
For Final Reports Only:			
<input type="checkbox"/> I intend to remain with my employer	<input type="checkbox"/> I do not intend to remain with my employer		

<u>II. Employer Information:</u>			
Employer Name:			
Email Address:		Telephone Number:	
Primary Practice Facility of Physician:			
Facility Name:		Address:	
City:	Zip:	County:	
Secondary Practice Facility of Physician (if applicable):			
Facility Name:		Address:	
City:	Zip:	County:	
Tertiary Practice Facility of Physician (if applicable):			
Facility Name:		Address:	
City:	Zip:	County:	

III. Physician Work Schedule: Provide your weekly work schedule by identifying the time you spend on direct patient care (excluding on-call hours).

<i>DAY</i>	<i>TIME (Start and End)</i>		<i>DAY</i>	<i>TIME (Start and End)</i>	
	<i>AM:</i>	<i>PM:</i>		<i>AM:</i>	<i>PM:</i>
<i>Monday</i>			<i>Friday</i>		
<i>Tuesday</i>			<i>Saturday</i>		
<i>Wednesday</i>			<i>Sunday</i>		
<i>Thursday</i>					

IV. Patient Information: Provide the total number of active patients at the primary practice site in the previous calendar year with totals, as applicable, for primary care, specialty care, and mental health services. Then provide a breakdown (percentage) of each of the following payer types by patient group for the previous calendar year.

<i>Primary Care</i>	<i>Specialty Care</i>	<i>Mental Health Care</i>	<i>Total</i>

	<i>Sliding Fee</i>	<i>Medicaid</i>	<i>Medicare</i>
<i>Pediatric/Adolescent</i>	%	%	
<i>Adult</i>	%	%	%

V. 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