

# FLORIDA VISA WAIVER PHYSICIAN PRACTICE STATUS REPORT



PLEASE TYPE OR PRINT CLEARLY

<input type="checkbox"/> J-1 Visa (Conrad 30) Waiver <input type="checkbox"/> NIW <input type="checkbox"/> HHS Waiver	Report Completion Date:
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<b>I. <u>Physician Information:</u></b>		
Name, Last:	First:	Middle:
Email Address:		FL License Number:
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	<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Specialist (specify):
Subspecialty (if applicable):		
Employment Start Date:		Employment End Date:
Report Number (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	

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

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

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

**IV. Patient Information:** Provide your total number of patients seen in the previous calendar year, 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>Group</i>	<i>Medicaid</i>	<i>Sliding Fee</i>	<i>Uncompensated Care</i>
<i>Pediatric/Adolescent</i>	%	%	%
<i>Adult</i>	%	%	%
<i>Geriatric</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