

**FLORIDA FOREIGN PHYSICIAN VISA WAIVER PROGRAM  
Employer Attestation**



**BEFORE ME**, the undersigned authority, personally appeared \_\_\_\_\_,  
who after being duly sworn deposes:

I, \_\_\_\_\_, of \_\_\_\_\_,  
*(Name of employer)* *(Name of facility)*

hereby certify, under penalty of the provisions of 18 U.S.C. 1001, that: (1) our facility is located  
at \_\_\_\_\_;  
*(Full physical address, county, FIPS code, census tract)*

(2) is located in a medical shortage area ( \_\_\_\_\_ ); and  
*(HPSA or MUA/P ID Number)*

(3) Provides medical care to Medicare and Medicaid and sliding fee scale patients.

I declare under the penalties of perjury that the foregoing is true and correct.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public

My commission expires: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_