

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott  
Governor

John H. Armstrong, MD, FACS  
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

## FLORIDA PHYSICIAN VISA WAIVER TRANSFER REQUEST FORM

**PLEASE TYPE OR PRINT CLEARLY**

<b>I. <u>Physician Information:</u></b>		
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):	

<b>II. <u>Employer Information:</u></b>		
Employer Name:		
Email Address:	Telephone Number:	
Address:		
City:	Zip:	County:
Employer Type:		
<input type="checkbox"/> For Profit <input type="checkbox"/> Non-Profit <input type="checkbox"/> Safety Net Provider (specify):		
Service Type:		
<input type="checkbox"/> Outpatient/Ambulatory <input type="checkbox"/> Hospitalist <input type="checkbox"/> Other (specify):		
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. 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>	%	%	%

**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 may be submitted electronically to: [FL.PCO@flhealth.gov](mailto:FL.PCO@flhealth.gov)**

Application materials may be mailed to:

State Primary Care Office  
Division of Public Health Statistics and Performance Management  
Florida Department of Health  
4052 Bald Cypress Way, Bin #C15  
Tallahassee, Florida 32399