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:_____/_____/_____