

# FLORIDA VISA WAIVER PHYSICIAN TRANSFER REQUEST FORM



**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):		

<b>II. <u>Employer Information:</u></b>		
Employer Name:		
Email Address:	Telephone Number:	
Address:		
City:	County:	Zip:
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:		
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. Patient Information:** Provide the total number of active patients at the 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>Group</i>	<i>Medicaid</i>	<i>Sliding Fee</i>	<i>Uncompensated Care</i>
<i>Pediatric/Adolescent</i>	%	%	%
<i>Adult</i>	%	%	%
<i>Geriatric</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