CONRAD 30 WAIVER PROGRAM

PHYSICIAN AGREEMENT

1. I, _____, have requested the Florida Department of Health (FDOH) to review my application for a waiver of the foreign residency requirement set forth in my visa. By this review, I am requesting that the FDOH recommend the U.S. Citizenship and Immigration Service (USCIS) approve such a waiver of the residency requirement. I understand and acknowledge that the review of this request is discretionary and that in the event a decision is made not to recommend the waiver, I hold the State of Florida, FDOH, its employees, or any and all individuals or organizations involved in the review process harmless from any action or lack of action made in connection with this request.
2. I understand and acknowledge that a FDOH recommendation to grant this request does not guarantee approval from the U.S. Department of State or the USCIS.
3. I further understand and acknowledge that the entire basis for the consideration of my request is FDOH's voluntary participation and mission to increase the availability of medical care in areas designated by the Secretary of the U.S. Department of Health and Human Services (USHHS) as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps).
4. I understand and agree that in consideration for the granting of a waiver by the USCIS, I shall render medical care services to patients, including the underserved, for a minimum of 40 hours per week within a designated HPSA or MUA/P in Florida. Such service shall commence not later than 90 days after I receive notification of approval by the USCIS and shall continue for a minimum of three years.
5. I agree to provide health services to individuals without discriminating against them because (a) they are unable to pay for those services or (b) payment for those health services will be made under Medicaid or Medicare. I will charge persons receiving services at the usual and customary rate prevailing in the HPSA or MUA/P in which services are provided, except persons at or below 200 percent of the federal poverty level as determined annually by the USHHS. All persons shall be charged on a sliding fee scale or shall not be charged if they are unable to pay for these services.
6. I expressly agree to provide written notification of the specific location and nature of my practice to FDOH at the time I receive notification of the granting of the waiver from USCIS and at the time I commence rendering services in the HPSA or MUA/P. I further understand and agree that relocation from a site approved in the application request to a different site must be approved by FDOH in writing prior to the relocation.
7. I agree to comply with the requirements set forth in Section 214 of the Immigration and Naturalization Act and to comply with all FDOH visa waiver program monitoring and reporting requirements.
8. I further certify that my prospective employer will structure my employment and the operations of the health care facility to facilitate my compliance with the requirements of my waiver, if granted.

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

_____
Date

_____
Printed Name of Physician

_____
Signature of Physician

USDOS Case #: