CONRAD 30 WAIVER PROGRAM



FLEX ADDENDUM

Physician Name:	USDOS Case #:
1) Describe the facility/practice location's geographic service area.	
2) Describe and provide evidence that the employer's current patient b neighboring HPSA (for example, a patient visit report that identifies t 6-12 months of service by patient origin ZIP code). [Do not send indiv	otal patient visits in the last
 3) Is the physician's specialty currently available in the geographic area(s) where the physician will be practicing? Physician's Specialty: 	
 Yes [How many other physicians practice this specialty?] No [Specify the nearest location where this service can be obtained:] 	