Florida HEALTH

CONRAD 30 WAIVER PROGRAM

FLEX ADDENDUM

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