FLORIDA NATIONAL INTEREST WAIVER PROGRAM

Application for Letter of Support

Only typed applications will be accepted.

I. Physician Information

Name: Last:	First:	Middle:
Email Address:	FL Medical License Number:	
Country of Birth:	Country of Legal Permanent Residence:	
Gender: ☐ Female ☐ Male	DOB:	Current Address:

Practice Type **(select only one)**:

☐ Family Medicine ☐ Internal Medicine - General ☐ Pediatrics - General

☐ Obstetrics/Gynecology - General ☐ Psychiatry

Did you complete your residency program in the state of Florida? ☐ Yes ☐ No (specify state):

Do you plan to remain in the state of Florida after NIW employment is over? ☐ Yes ☐ No

II. Employer Information

Employer Name:			
Address:			
City:	State:	ZIP:	County:
Contact Name:		Telephone Number:	
Email Address:			

III. Practice Site Information

If there are more than four site locations, they must be submitted on a separate sheet. All location information must be included.

Primary Practice Site Location of Physician			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	ZIP:	County:
Contact Name:		Contact Phone:	
HPSA Score:	HPSA Name:	HPSA ID Number:	

Secondary Practice Site Location of Physician			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	ZIP:	County:
Contact Name:		Contact Phone:	
HPSA Score:	HPSA Name:	HPSA ID Number:	

Tertiary Practice Site Location of Physician			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	ZIP:	County:
Contact Name:		Contact Phone:	
HPSA Score:	HPSA Name:		HPSA ID Number:

Quaternary Practice Site Location of Physician			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	ZIP:	County:
Contact Name:		Contact Phone:	
HPSA Score:	HPSA Name:		HPSA ID Number:

III. Patient Information

Provide a breakdown of each payer type by patient group for the employer for the previous calendar year.

	Sliding Fee/ Charity Care	***Medicaid*** *(including dual eligible)*	***Medicare Only***	***Private Insurance/Other***	***Total***
Pediatric (<18)	%	%	N/A	%	%
Adult (>18)	%	%	%	%	%
				GRAND TOTAL	100%

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

Attorney Contact Information (if applicable):

Name: Telephone: Email: