FLORIDA PHYSICIAN NATIONAL INTEREST WAIVER
Request for Acknowledgement Letter of Work in the Public Interest

Additional Employment Information
(for reporting all 5 years of service with multiple past employers)

Only typed requests will be accepted.

Applicant's full name:

SECTION 3 - Employer Information

Employer Name:				
Address:				
City:	State:		ZIP:	County:
Contact Name:			Telephone Number:	
Email Address:				
Please Check One:	☐ For Profit	☐ Non-Profit	☐ Government Entity	☐ Other (specify:)

SECTION 4 - Employment Information

The beginning date of employment with this employer:
The ending date of employment with this employer:
Does/Did the facility or practice sponsoring the physician agree to provide health services to individuals without discriminating against them because: (a) they were unable to pay for those services or (b) payment for those health services will be made under Medicare and Medicaid, or a state equivalent indigent health care program (including KidCare)? ☐ Yes ☐ No
Does/Did the facility provide care on a sliding fee payment arrangement for uninsured, low-income patients and is/was this notice publicly posted in the facility? ☐ Yes ☐ No

SECTION 5 - Practice Location Information

If there are more than three 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:
If not in a HPSA:	MUA/P Service Area Name:		MUA/P Number:
The majority of patients are:	☐ Inpatient	☐ Outpatient	☐ Other (specify:)

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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:
If not in a HPSA:	MUA/P Service Area Name:		MUA/P Number:
The majority of patients are:	☐ Inpatient	☐ Outpatient	☐ Other (specify:)

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:
If not in a HPSA:	MUA/P Service Area Name:		MUA/P Number:
The majority of patients are:	☐ Inpatient	☐ Outpatient	☐ Other (specify:)

SECTION 6 - Payer Type

Your Grand Total cannot exceed 100%.

Provide a breakdown of each payer type by the 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	%	0.00 %
Adult (>18)	%	%	%	%	0.00 %
				GRAND TOTAL	0.00 %

Your Grand Total is less than 100%. Please update your percentages.

NOTICE: Any person who knowingly makes a false statement or misrepresentation on this form is subject to penalties under section 837.06, Florida Statutes, which may include fines, imprisonment, or both.