# SOUTHEAST CRESCENT REGIONAL COMMISSION
## Request for Letter of Support

### SECTION 1 - Applicant Information

| | | |
|---|---|---|
| Name: Last: | First: | Middle: |
| Email Address: | FL Medical License Number: | |
| US DOS Case #: | NPI 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 ☐ Other:

Did you/will 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 your SCRC employment is over? ☐ Yes ☐ No

### SECTION 2 - 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 3 - Employment Information

Is there an employment contract? ☐ Yes ☐ No

| | |
|---|---|
| Beginning date on employment contract: | Ending date on employment contract : |

Does contract have non-compete clause or any other restrictive covenant enforceable against the foreign medical graduate after the tenure of the contract period? ☐ Yes ☐ No

Did employer make a good-faith effort to recruit an American physician for the opportunity in the same salary range, without success, for a period of 45 days, and said recruitment was national, in-state, and state medical school in scope? ☐ Yes ☐ No

Does 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 the facility provide care on a sliding fee payment arrangement for uninsured, low-income patients and have this notice publicly posted in the facility? ☐ Yes ☐ No

Does the facility charge more than the usual and customary rate prevailing in the geographic area in which the services are provided.? ☐ Yes ☐ No

## SECTION 4 - 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: | |
| Is the site located in a: ☐ HPSA ☐ MUA/P | | HPSA Score: | |
| HPSA/MUA/P Name: | | | HPSA/MUA/P 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: | |
| Is the site located in a: ☐ HPSA ☐ MUA/P | | HPSA Score: | |
| HPSA/MUA/P Name: | | | HPSA/MUA/P 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: | |
| Is the site located in a: ☐ HPSA ☐ MUA/P | | HPSA Score: | |
| HPSA/MUA/P Name: | | | HPSA/MUA/P ID Number: |

## SECTION 5 - Immigration Attorney Information (if applicable)

| Immigration Attorney Name: | | |
|---|---|---|
| Immigration Firm Name (if applicable): | | |
| Address: | | |
| City: | State: | ZIP: |
| Contact Name (Other than attorney if applicable): | | Telephone Number: |
| Email Address: | | |

## SECTION 6 - Payer Type

Your Grand Total cannot exceed 100%.

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 | % | 0.00 % |
| ***Adult (>18)*** | % | % | % | % | 0.00 % |
| | | | | GRAND TOTAL | 0.00 % |

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

## SECTION 7 - Attestations

I hereby attest that all information and statements contained herein are true and do not misrepresent facts. I further attest that I have not evaded or suppressed any information contained in this application, including any additional site locations on a separate sheet. The information I have supplied on this application is complete, true, and accurate. To the best of my knowledge and belief, I am eligible for this program.

| Applicant's Signature | Date | Applicant's Printed Name |
|---|---|---|

I attest that the physician that this request is for will be providing medical care and employed at only the practice locations above, including any additional site locations on a separate sheet. I further acknowledge that all information and statements contained herein are true and do not misrepresent fact and that I have not evaded or suppressed any information contained in this request form.

| Employer's Signature | Date | Employer's Printed Name |
|---|---|---|

Print Form

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