SOUTHEAST CRESCENT REGIONAL COMMISSION
Request for Letter of Support

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	☐ Other:

II. Employer Information

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

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

III. 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

IV. Practice Site 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:

V. 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%

VI. 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:

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.