

FLORIDA HHS EXCHANGE VISITOR PROGRAM
Request for Letter of Support/Acknowledgement of Placement by HHS

Only typed requests will be accepted.

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: <input type="checkbox"/> Female <input type="checkbox"/> Male	DOB:	Current Address:
Practice Type (select only one):		
<input type="checkbox"/> Family Medicine <input type="checkbox"/> Internal Medicine - General <input type="checkbox"/> Pediatrics - General		
<input type="checkbox"/> Obstetrics/Gynecology - General <input type="checkbox"/> Psychiatry		
Did you/will you complete your residency program in the state of Florida? <input type="checkbox"/> Yes <input type="checkbox"/> No (specify state): _____		
Do you plan to remain in the state of Florida after your HHS Exchange Visitor employment is over? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION 2 - Employer Information

Employer Name:			
Address:			
City:	State:	ZIP:	County:
Contact Name:		Telephone Number:	
Email Address:			
Please Check One:	<input type="checkbox"/> For Profit	<input type="checkbox"/> Non-Profit	<input type="checkbox"/> Government Entity <input type="checkbox"/> Other (specify: _____)

SECTION 3 - Employment Information

Is there an employment contract? <input type="checkbox"/> Yes <input type="checkbox"/> No			
The beginning date on the employment contract:			
The ending date on the employment contract :			
Does the contract have a non-compete clause or any other restrictive covenant enforceable against the foreign medical graduate after the tenure of the contract period? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does the facility provide care on a sliding fee payment arrangement for uninsured, low-income patients and has this notice publicly been posted in the facility? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does the facility charge more than the usual and customary rate prevailing in the geographic area in which the services are provided.? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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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:	
HPSA Score:	HPSA Name:		HPSA ID Number:
The majority of patients are:		<input type="checkbox"/> Inpatient	<input type="checkbox"/> Outpatient
		<input type="checkbox"/> Other (specify:)	

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:
The majority of patients are:		<input type="checkbox"/> Inpatient	<input type="checkbox"/> Outpatient
		<input type="checkbox"/> 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:
The majority of patients are:		<input type="checkbox"/> Inpatient	<input type="checkbox"/> Outpatient
		<input type="checkbox"/> Other (specify:)	

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:			

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SECTION 6 - Payer Type

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

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

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

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.