



CONRAD 30 VISA WAIVER PROGRAM

Florida DOH Sponsorship Application

Only typed applications will be accepted.

SECTION 1 - Applicant Information

Name: Last:	First:	Middle:
USDOS Case#:	NPI Number:	
Email Address:	FL Medical License Number:	
Country of Birth:	Country of Legal Permanent Residence:	
Gender: ☐ Female ☐ Male	DOB:	
Current Address:		
Specialty, as defined in 64W-1.002(8) & (9) (select only one):		
☐ Family Medicine	☐ Internal Medicine - General	☐ Pediatrics - General
☐ Obstetrics/Gynecology - General	☐ Psychiatry	
☐ Specialist (specify):	Subspecialty (if applicable):	
If you do not currently reside in Florida, do you agree to reside in Florida and only treat patients in Florida for the duration of your approved Conrad 30 employment? ☐ Yes ☐ No [if no, why not? _____]		
Did you/Will you complete your residency program in the state of Florida? ☐ Yes ☐ No (specify state): _____		

SECTION 2 - Employer Information

Employer Name:			
Address:			
City:	State:	ZIP:	County:
Contact Name:		Telephone Number:	
Email Address:			
Employer Type: (choose 1) ☐ For Profit ☐ Non-Profit ☐ Safety Net Provider			

SECTION 3 - Practice Location Information

If there are more than five 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 at Location:		Contact Phone:	
Employment Begin Date:		Employment End Date:	
HPSA ID Number:	HPSA Name:	HPSA Score:	
The majority of practice patients are: ☐ Outpatient ☐ Inpatient ☐ 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_at Location:		Contact Phone:	
Employment Begin Date:		Employment End Date:	
HPSA ID Number:		HPSA Name:	
		HPSA Score:	
The majority of practice patients are: ☐ Outpatient ☐ Inpatient ☐ Other (specify):			

Tertiary Practice Site Location of Physician			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	ZIP:	County:
Contact Name at Location:		Contact Phone:	
Employment Begin Date:		Employment End Date:	
HPSA ID Number:		HPSA Name:	
		HPSA Score:	
The majority of practice patients are: ☐ Outpatient ☐ Inpatient ☐ Other (specify):			

Quaternary Practice Site Location of Physician			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	ZIP:	County:
Contact Name at Location:		Contact Phone:	
Employment Begin Date:		Employment End Date:	
HPSA ID Number:		HPSA Name:	
		HPSA Score:	
The Majority of practice patients are: ☐ Outpatient ☐ Inpatient ☐ Other (specify):			

Quinary Practice Site Location of Physician			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	ZIP:	County:
Contact Name at Location:		Contact Phone:	
Employment Begin Date:		Employment End Date:	
HPSA ID Number:		HPSA Name:	
		HPSA Score:	
The Majority of practice patients are: ☐ Outpatient ☐ Inpatient ☐ Other (specify):			

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SECTION 4 - 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>
<i>Pediatric (<18)</i>	%	%	N/A	%	%
<i>Adult (>18)</i>	%	%	%	%	%
TOTALS	%	%	%	%	%

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 - 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.

I understand that if I am contractually obligated to return to my home country upon completion of the J-1 exchange visitor program, it is my responsibility to obtain a "no objection" statement in writing from my home country that will be submitted directly to the US Department of State.

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 document.

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.