CONRAD 30 WAIVER PROGRAM

Practice Status Report

Only typed applications will be accepted.

SECTION 1 - Physician Information

Name: Last:	First:	Middle:
USDOS Case #:	NPI Number:	
Email Address:	FL Medical License Number:	

Practice Type **(select only one)**:

☐ Family Medicine ☐ Internal Medicine - General ☐ Pediatrics - General

☐ Obstetrics/Gynecology - General ☐ Psychiatry

☐ Specialist (specify): Subspecialty (if applicable):

Date J-1 Waiver approved by USCIS: **Be sure to include the USCIS Notice of Action form

Employment Status (select one):

☐ Year 1 Beginning Date: _____ Ending Date: _____

☐ Year 2 Beginning Date: _____ Ending Date: _____

☐ Year 3 Beginning Date: _____ Ending Date: _____

FINAL REPORT (Year 3):

Do you plan to remain in the state of Florida after your Conrad 30 employment is over? ☐ Yes ☐ No

Do you plan to remain with your current employer after your Conrad 30 employment is over? ☐ Yes ☐ No

SECTION 2 - Employer Information

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

Employer Type: (choose 1) ☐ For Profit ☐ Non-Profit ☐ Safety Net Provider

SECTION 3 - Practice Location Information

Primary Practice Site Location of Physician			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	ZIP:	County: SELECT COUNTY
Contact Name:		Contact Phone:	

Majority of Practice Patients Are: ☐ Outpatient ☐ Inpatient ☐ Other (specify):

Secondary Practice Site Location of Physician			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	ZIP:	County: SELECT COUNTY
Contact Name:		Contact Phone:	
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: SELECT COUNTY
Contact Name:		Contact Phone:	
☐ Outpatient ☐ Inpatient ☐ Other (specify):			

Quaternary Practice Site Location of Physician			
Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	ZIP:	County: SELECT COUNTY
Contact Name:		Contact Phone:	
Majority of Practice Patients Are: ☐ Outpatient ☐ Inpatient ☐ Other (specify):			

Additional site locations must be submitted on separate sheet. All location information must be included.

SECTION 4 – Physician Work Schedule

Provide your weekly work schedule by identifying the time you spend on direct patient care (excluding on-call hours).

DAY	TIME (Start and End)		DAY	TIME (Start and End)		DAY	TIME (Start and End)	
	AM	PM		AM	PM		AM	PM
Monday			Thursday			Saturday		
Tuesday			Friday			Sunday		
Wednesday								

SECTION 5 - Payer Type

Provide a breakdown of each payer type by patient group for the **employer** for the report/employment year.

	Sliding Fee/ Charity Care	Medicaid (including dual eligible)	Medicare Only (not including dual eligible)	Private Insurance/Other	Total
Pediatric (<18)	%	%	N/A	%	%
Adult (>18)	%	%	%	%	%

Provide a breakdown of each payer type by patient group for the **J-1 physician** for the report/employment year. 0.00

	Sliding Fee/ Charity Care	Medicaid (including dual eligible)	Medicare Only (not including dual eligible)	Private Insurance/Other	Total
Pediatric (<18)	%	%	N/A	%	%
Adult (>18)	%	%	%	%	%

0.00

SECTION 6 - 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:
Contact Email Address:		

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 document, including any additional site locations on a separate sheet. The information I have supplied on this document is complete, true, and accurate.

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.