CONRAD 30 WAIVER PROGRAM

EMPLOYER PRACTICE LOCATION ATTESTATION

Health Professional Shortage Area (HPSA)
Practice Location

(Provide one form for each practice location.)

I, _____, of_____,
hereby certify, under penalty of the provisions of 18 U.S.C. § 1001, that:

(1) our facility/site is located at _____;

(2) is located in a health professional shortage area (_____); and

(3) provides medical care regardless of a patient's ability to pay (this includes accepting Medicaid, Children's Health Insurance Program, Medicare and the indigent/uninsured through a sliding fee scale or charity care program).

I declare under the penalties of perjury that the foregoing is true and correct.

_____ _____
Date Printed Name of Employer

_____
Signature of Employer

Physician Name: _____ USDOS Case #: _____