CONRAD 30 WAIVER PROGRAM

PRACTICE STATUS REPORT

Only typed applications will be accepted.

Report/Employment Year	From Date:	To Date:

I. Physician Information

Name: Last:	First:	Middle:
Email Address:	FL Medical License Number:	
Date Waiver approved by USCIS:	Date Employment Started:	

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

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

☐ Obstetrics/Gynecology - General ☐ Psychiatry

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

Employment Status (select one): ☐ Year 1 ☐ Year 2 ☐ Year 3

FINAL REPORT:

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

II. 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

III. Practice Site Information

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

IV. 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								

V. Patient Information

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 **physician** 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)	%	%	%	%	%

IV. 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