# CONRAD 30 WAIVER PROGRAM

## EMPLOYER PRACTICE LOCATION ATTESTATION

### Health Professional Shortage Area (HPSA)
### Practice Location Affidavit

*(Provide one typed form for each practice location.)*

I, _____, of _____,
(Name) (Business/Practice Name)

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

(1) Our facility/site is located at _____
(Physical Address)

(2) Our facility/site is: (check one):

☐ NOT located in a HPSA but treats patients who reside in a HPSA (Flex Addendum(s) must be included in the application packet), or

☐ located in a HPSA

HPSA Name: _____

HPSA ID: _____

HPSA Score: _____

(3) Our facility/site accepts the following: (Check all that apply)

☐ Medicaid
☐ Children's Health Insurance Program/Florida KidCare
☐ Medicare
☐ 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 #: _____