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 subsections 64W-1.002(6) & (7), F.A.C. (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):			

SECTION 4 – Payer Type

Provide a breakdown of each payer type by the patient group for the employer for the previous calendar year.

	Sliding Fee/ Charity Care	***Medicaid*** *(including dual eligible)*	***Medicare Only***	***Private Insurance/Other***	***Total***
Pediatric (<18)	%	%	N/A	%	%
Adult (>18)	%	%	%	%	%
TOTALS	%	%	%	%	100%

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 applicant 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.