CONRAD 30 WAIVER PROGRAM
Florida DOH Sponsorship Application

Only typed applications will be accepted.

USDOS Case #:

I. Physician Information

Name: Last:	First:	Middle:
Email Address:	FL Medical License Number*:	
Country of Birth:	Country of Legal Permanent Residence:	
Gender: ☐ Female ☐ Male	DOB:	Current Address:

Specialty, as defined in Rule 64W-1.002(6) & (7) (select only one):

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

☐ Obstetrics/Gynecology - General ☐ Psychiatry

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

Did you complete your residency program in the state of Florida? ☐ Yes ☐ No (specify state):

Do you plan to remain in the state of Florida 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

If there are more than four 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:	
HPSA Score: HPSA Name:		HPSA ID Number:	
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:	
HPSA Score:	HPSA Name:		HPSA ID Number:
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:	
HPSA Score:	HPSA Name:		HPSA ID Number:
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:	
HPSA Score:	HPSA Name:		HPSA ID Number:
Majority of Practice Patients Are: ☐ Outpatient ☐ Inpatient ☐ Other (specify):			

III. Patient Information

Provide a breakdown of each payer type by 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)	%	%	%	%	%
				GRAND TOTAL	100%

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

Attorney Contact Information (if applicable):

Name: Telephone: Email: