



CONRAD 30 WAIVER PROGRAM
PHYSICIAN ATTESTATION OF EXCLUSIVITY

I, _____, hereby declare and certify, under penalty of the provisions of 18 U.S.C. § 1001, that: (1) I have sought or obtained the cooperation of the Florida Department of Health which is submitting an Interested Government Agency request on behalf of me under the Conrad 30 Program to obtain a waiver of the two-year home residency requirement; and (2) I do not now have pending nor will I submit during the pendency of this request, another request to any U.S. Government department or agency or any equivalent, to act on my behalf in any matter relating to a waiver of my two-year home residence requirement.

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

Date

Printed Name of Physician

USDOS Case #

Signature of Physician

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.