

## **CONRAD 30 WAIVER PROGRAM**

## **PRACTICE STATUS REPORT**

Only typed applications will be accepted.

Report/Employment Year	From Date:		To Date:				
	I. <u>Physici</u>	an Information					
Name: Last:	First:		Middle:				
Email Address:	FL Medical Licen	FL Medical License Number:					
Date Waiver approved by USC	Date Employmen	Date Employment Started:					
Practice Type (select only one)	:						
☐ Family Medicine	☐ Internal Me	dicine - General	cine - General Pediatrics - General				
☐ Obstetrics/Gynecology - Ge	eneral Psychiatry						
☐ Specialist (specify):	Subs	specialty (if applicable	e):				
Employment Status (select on	e):	☐ Year 2	Year 3				
FINAL REPORT:							
Do you plan to remain in the s	tate of Florida after your Con	rad 30 employment is	over? \( \subseteq \text{ Ye}	es 🗌 No			
Do you plan to remain with you	ur current employer after you	r Conrad 30 employm	ent is over?	☐ Yes ☐ No			
	II Francis	von Information					
	II. Employ	ver Information					
Employer Name:							
Address:							
City:	State:	ZIP:		County:			
Contact Name:		Telephone Numb	Telephone Number:				
Email Address:							
Employer Type: (choose 1)	☐ For Profit	☐ Non-Profit		☐ Safety Net Provider			
	III. <u>Practice</u>	Site Information					
Primary Practice Site Location	on of Physician						
Facility/Practice Name:		Weekly Direct Patient Care Hours:					
Address:							
City:	State:	ZIP:		County:			
Contact Name:		Contact Phone:	Contact Phone:				
Majority of Practice Patients A	re: Outpatient Ir	patient	r (specify):				
Secondary Practice Site Loc	ation of Physician						
Facility/Practice Name:			Weekly Dire	ect Patient Care Hours:			
Address:							
City:	State:	ZIP:		County:			
Contact Name:		Contact Phone:					
Majority of Practice Patients A	re: Coutnatient Clr	nationt	r (specify):				

-acility/Fractic	ce Name:						Neekly Direct	Patient Ca	re Hours:
Address:									
City:		State:			ZIP:		Co	ounty:	
Contact Name	»: 				Contac	ct Phone:			
Majority of Pra	actice Patients	Are: O	utpatient [	] Inpa	atient	Other (	specify):		
				_					
Quaternary Pr	ractice Site L	ocation of P	hysician						
Facility/Practic	e Name:						Neekly Direct	Patient Ca	re Hours:
Address:					,		<del></del>		
City:		State:			ZIP:		Co	ounty:	
Contact Name	×				Contac	ct Phone:			
Majority of Pra			•	] Inpa			specify):		
	Additional site	locations must	t be submitted on	separ	rate shee	t. All location i	nformation must	be included	l.
			IV. <u>Physic</u>	cian V	Nork Sc	:hedule			
Provide your we	ekly work sch	edule by iden	ntifying the time	you s	spend or	n direct patie	nt care (e <u>xclud</u>	ing on-call	hours).
DAY	TIM (Start an		DAY			ME nd End)	DAY	/Sta	TIME
DAT	(Start an	nd End) PM	DAT		(Start al AM	nd End) PM	DA 1	(Sta	rt and End) PM
Monday			Thursday				Saturday		
	+						Gatarday		
Tuesday			Friday				Sunday		
Tuesday Wednesday			Friday						
-				tient <u>l</u>	nforma	tion			
Wednesday	-t of each		V. <u>Pat</u>				Sunday	t-voor	
-			V. <u>Pat</u> y patient group	for the	e <b>emplo</b>	<b>yer</b> for the re	Sunday		Total
Wednesday	Slidi	payer type by ing Fee/ rity Care	V. <u>Pat</u>	for the	e emplo		Sunday  eport/employm  Priva	te	Total
Wednesday	Slidi Char	ing Fee/	V. <u>Pat</u> y patient group  Medicaid	for the	e emplo	oyer for the re licare Only	Sunday  eport/employm Priva Insurance	te	Total
Wednesday Provide a break	Slidi Char	ing Fee/ rity Care	V. Pat y patient group Medicaid (including dual elig	for the	e emplo	oyer for the relationships the second	sunday  eport/employm Priva Insurance	te e/Other	
Wednesday Provide a break	Slidi Char 3)	ing Fee/ rity Care %	V. Pat y patient group Medicaid (including dual elig %	for the	e emplo	oyer for the re licare Only uding dual eligible N/A %	sport/employm Priva Insurance	te e/Other %	%
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