

Florida Department of Health  
Request for Letter of Support for Health & Human Services J1 Program

PHYSICIAN	PRIMARY CARE SPECIALTY
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ADDRESS	CITY	ZIP
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TELEPHONE #	FAX #	EMAIL
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**Documentation Required: Include physician's curriculum vitae/resume.**

PLEASE LIST ALL CLINIC LOCATIONS WHERE THE PHYSICIAN WILL PROVIDE SERVICES.

HEALTH CARE FACILITY	CONTACT PERSON
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ADDRESS	CITY	ZIP
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TELEPHONE #	FAX #	EMAIL
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**Documentation Required: Include a narrative about the scope of practice.**

1. The health care facility is (check all that apply):

- For-Profit   
  Non-Profit   
  Government Organization   
  Community Health Center  
 Public Hospital District   
 Other Publicly Funded Provider (*Specify*) \_\_\_\_\_  
 Other (*Specify*) \_\_\_\_\_

2. Please note the percentage of total patient visits from the preceding 12 months that the health care facility provides to each of the following populations:

Medicaid \_\_\_\_\_%                      Discounted/Sliding Fee \_\_\_\_\_%  
 Medicare \_\_\_\_\_%                      Uncollectable/Write-off \_\_\_\_\_%

**Documentation Required: Submit a report or other documentation that supports the information provided above. INCLUDE MEDICAID PROVIDER NUMBER.**

3. Does the health care facility have an existing discounted/sliding fee schedule?

- Yes     No

**Documentation Required: Submit a copy of the health care facility discounted/sliding fee schedule, along with a letter assuring a firm commitment by the employer to apply the discounted/sliding fee schedule.**

4. Does the health care facility have a notice conspicuously posted of the availability of a discounted/sliding fee schedule?  Yes  No

**Documentation Required:** Submit a copy of the public notice of the availability of a discounted/ sliding fee schedule. The public notice shall be posted in the patient waiting room and shall include the practice site's commitment to serve all patients regardless of their ability to pay or their enrollment in Medicare or Medicaid.

5. Proposed Physician Weekly Work Schedule (If more than one clinic location, provide schedule for each)

DAY	TIME (Start and End)		TOTAL HOURS
	AM:	PM:	
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

**PRIVATE EMPLOYERS ONLY**

6. Additional documents to be submitted with this application:
- a) Narrative of any volunteer services provided by the health care facility or planned services for the physician.
  - b) Narrative of health care facility's involvement with other community safety-net providers (county health department, community health center, etc.)

*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.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Title

**Submit the completed application and required documentation to:**

Florida Department of Health  
Office of Health Professional Recruitment  
4052 Bald Cypress Way, Bin C-15  
Tallahassee, Florida 32399-1735  
Fax (850) 922-6296