

Florida Department of Health  
**State 30/J-1 Visa Waiver Program**  
**2011-2012**

**Purpose:** The Department of Health (DOH) Office of Health Professional Recruitment (HPR) administers the State 30/J-1 Visa Waiver Program. Our goal is to improve access to health care services, and to address health disparities, within federally designated health professional shortage areas (HPSAs) and medically underserved areas/populations (MUAs/MUPs).

**General Guidelines:**

- Up to 30 waivers will be recommended from October 1 through September 30 of each year (cycle).
- Applications must receive a minimum score of **45** in order to be recommended for a waiver.
- Applicants who meet the requirements will be requested to apply for a waiver through the U.S. Department of Health and Human Services.
- A physician must practice clinical medicine in a HPSA or MUA/P for the required three (3) year obligation period.
- Employment must be full-time (not less than 40 hours a week) for three years. The required 40 hours per week are exclusive of time that is spent on-call, on inpatient care, on hospital rounds, on emergency room duties, or on travel. **Exceptions: Up to 8 hours per week** may be providing follow-up care for the physician's **own** patients in the hospital. **OB** physicians must provide a minimum of **21 hours per week** in a clinical outpatient setting.
- Of the 40 hours per week, not less than 20 hours per week must be providing clinical primary care and not more than 20 hours per week may be providing clinical specialty care.
- For physicians granted a J-1 visa waiver, a transfer from one site to another is not permitted without prior written approval by DOH.
- The **facility**, upon recommendation of waiver application, must: accept Medicaid/Medicare clients; employ a discounted/sliding fee schedule for low-income clients; and post a notice in a conspicuous place in the waiting area that all clients will be seen regardless of their ability to pay. It is expected that within one year of the J-1 physician placement, the facility's total patient visits should consist of (*at a minimum*) 30% combined Medicaid, discounted/sliding fee schedule and uncompensated care.
- DOH has the *discretion* to limit the number of waiver recommendations for employers who submit multiple applications. Exceptions will be applications from safety-net providers identified above.
- There are no restrictions regarding the type of subspecialists allowed, with the exception of those subspecialists involved in care that is not medically essential, such as, cosmetic surgery.
- Past compliance with the program guidelines will be considered.

### **Program Preference/Priority Criteria:**

- Priority is given to safety-net providers. For the purpose of this program, safety-net providers are: county health departments, federally qualified health centers (and look-alikes), community mental health centers, homeless clinics, public, university-based and critical access hospitals and associated clinics; state correction and psychiatric facilities; and certified rural health clinics.
- Priority is given to applications for full-time primary care. For the purpose of this program, primary care specialties are: Family Practice, Pediatrics, Internal Medicine, Obstetrics/ Gynecology, Geriatrics, Infectious Disease or Psychiatry.
- Preference is given to placements in Health Professional Shortage Areas (HPSAs) having the greatest unmet need for primary care physicians. Unmet need is the number of primary care physicians needed to cause the HPSA to no longer meet the threshold ratio for designation. Only the number of physicians needed to eliminate the physician shortage will be recommended.

### ***Additional Guidelines - Specialist Waivers***

- Of the 30 waivers, 5 are available for full-time specialists.
- The physician may be board certified or board eligible in any specialty/sub-specialty, but must provide clinical services.
- Of the 40 hour work week, the physician may provide clinical services in an outpatient clinic, a hospital setting or a combination.
- Additional waivers for full-time specialists will be considered if there are unused waivers after the application review and scoring process is complete.

### ***Additional Guidelines - Non-HPSA-MUA/P (FLEX) Waivers***

Revisions to Federal Law (Public Law 108-441), allow State Health Departments to make recommendations for placements in facilities that are not located in a designated area (HPSA, MUA/P), but serve the population that resides in neighboring designated areas.

- Of the 30 waivers, up to 5 *may be* available for non-HPSA-MUA/P locations. The physician must provide clinical services. The clinical services may be primary care, specialty care or a combination.
- Non-HPSA-MUA/P (FLEX) waivers will be considered **ONLY** if there are unused waivers after the initial application review and scoring period. Only those applications received by the established deadline will be considered.

## Procedures for Submission and Review of Applications

Applications will be accepted each cycle through the end of the business day on the established deadline. **For the October 1, 2011-September 30, 2012 cycle, the deadline for submitting applications is November 7, 2011.** Applications received after the deadline will not be considered.

After the established deadline, applications will be reviewed and scored. Applications will be reviewed competitively and final determinations will be made on the basis of the eligibility requirements and selection criteria specified. Applicants will be notified of the decision to recommend or not recommend their application.

If approved, additional documentation will be requested, if needed. All documentation must be received by DOH in a timely manner in order to ensure submission to USDOS prior to the end of the cycle. Once the additional documentation has been received, DOH will forward one entire application packet to the United States Department of State (USDOS). Application packages will be sent certified mailed, return receipt requested. Applicants will receive notification that the application has been forwarded. Applicants will be notified directly from the USDOS of their approval/denial. DOH approval does not guarantee approval from the USDOS or the Bureau of Citizenship and Immigration Services.

**NOTE:** The J-1 Physician must have a Waiver Review File Number prior to a completed application being forwarded to the USDOS. If a Waiver Review File Number has not yet been requested, you may do so online at [http://travel.state.gov/visa/temp/info/info\\_1296.html](http://travel.state.gov/visa/temp/info/info_1296.html).

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

Department of Health J-1 Visa Waiver Program State Primary Care Office 4052 Bald Cypress Way, Bin C-15 Tallahassee, Florida 32399-1735
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For information, call or email:  
(850) 245-4444, Ext. 2704; Karen\_Lundberg@doh.state.fl.us

## Needed Documents

If your application is approved by DOH, and these documents have not already been included, you will be asked to submit one copy of the following (please note that items 1) and 2) must be included with the waiver application):

- 1) **Curriculum Vitae (J-1 physician)**
- 2) **Employment Contract - Contract Requirements**
  - a) The physician and the head of the health care facility must sign the contract
  - b) The date that the contract is signed should be included in the contract
  - c) A minimum of 40 hours weekly to provide patient care only
  - d) A three-year term

e) A statement from the foreign medical graduate agreeing to the contractual requirements set forth in Section 214 (1) of the Immigration and Nationality Act, as follows:

--The alien demonstrates a bona fide offer of "full-time" (40 hrs.) employment at a health facility and agrees to begin employment at such facility within 90 days of receiving such waiver and agrees to continue to work in accordance with paragraph (2) at the health care facility in which the alien is employed for a total of not less than 3 years (Unless the Attorney General determines that extenuating circumstances such as the closure of the facility or hardship to the alien would justify a lesser period of time)

--The alien agrees to practice medicine in accordance with paragraph (2) for a total of not less than 3 years only in the geographic area or areas, which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals.

3) **Data Sheet DS-3035** Assurance from the bank that \$215 processing fee paid (form DS-3035 can be found at: <http://travel.state.gov/pdf/ds3035.pdf>)

4) **Physician Attestation** (sample provided)

I, \_\_\_\_\_, hereby declare and certify, under penalty of the provisions of 18USC.1001, that:  
(1) I have sought or obtained the cooperation of the \_\_\_\_\_ Department of Health which is submitting an IGA 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.

5) **Employer Attestation** (sample provided)

#### **U.S. DEPARTMENT OF STATE EMPLOYER ATTESTATION**

I, (name), (title), of (facility), hereby certify, under penalty of the provisions of 18 U.S.C. 1001, that our facility located at (address), (county), (FIPS code), (census tract); is located in a Health Professional Shortage Area (HPSA ID #); and provides medical care to Medicare and Medicaid eligible patients and indigent, uninsured patients.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

6) **IAP-66/DS-2019 Forms** Must be submitted in chronological order with the "Beginning a new program" first.

7) **Letter From Facility** that indicates a desire to hire physician and recruitment efforts.

8) **Personal Statement** from physician regarding his/her reasons for not wishing to fulfill the two-year home country residence requirement to which the FMG agreed at the time of acceptance of exchange visitor status

9) **Explanation For Out of Status** if FMG spent any period of time in some other visa status, out of status, or outside of the US.

10) **Form G-28** or letterhead from law office, if attorney represents applicant

- 11) **I-94 Entry and Departure Cards** Photo copies, front and back
- 12) **A “No Objection” Statement** from the visitor’s government *if* foreign government funding is involved

### **Monitoring and Reporting Requirements**

Notification of waiver status and commencement of employment must be submitted to the Department of Health (DOH) upon receipt of written notification of approval from the Bureau of Citizenship and Immigration Service (BCIS). This notification must include the date the 3-year obligation commences.

The Department of Health (or representative) may conduct periodic monitoring of the J-1 visa waiver physicians and the practice sites through site visits, telephone calls or requests for written reports (Attachment 1.) Violation of any of the agreed upon conditions by the employer may result in denial of future requests for J-1 visa waivers. Violation of any of the agreed upon conditions by the physician may result in referral of the physician to the appropriate BCIS Office.

The physician and/or employer shall, upon reasonable notice and during normal business hours, grant DOH representatives, who shall maintain full confidentiality and comply with HIPAA regulations, reasonable access to all records maintained by the physicians’ practice, which are pertinent to ascertaining compliance with these guidelines. DOH representatives may perform audits for compliance of these guidelines.

Other primary care providers of indigent care in the community/county may be notified of the J-1 physician placement. The physician name and practice location may be posted on the DOH Office of Health Professional Recruitment (HPR) website as a provider of primary health care that accepts Medicare, Medicaid and utilizes a discounted/sliding fee schedule for the uninsured population.

Contract changes which result in termination of employment, change in practice scope, and/or relocation from a site approved in the application request to a new site must be presented in writing to DOH HPR at least 30 days prior to the change.

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

### J-1 PHYSICIAN WAIVER AFFIDAVIT

**BEFORE ME,** the undersigned authority, personally appeared \_\_\_\_\_, who after being duly sworn deposes:

1. My name is \_\_\_\_\_. I have requested the Florida Department of Health (DOH) to review my application for a waiver of the foreign residency requirement set forth in my J-1 Visa. By this review, I am requesting that the DOH recommend that the U.S. Immigration and Naturalization Service approve such a waiver of the residency requirement. I understand and acknowledge that the review of this request is discretionary and that in the event a decision is made not to recommend the waiver, I hold the State of Florida, DOH, its employees and/or any and all individuals or organizations involved in the review process harmless from any action or lack of action made in connection with this request.
2. I understand and acknowledge that a DOH recommendation to grant this request does not guarantee approval from the U.S. Department of State and/or the Bureau of Citizenship and Immigration Services (BCIS).
3. I further understand and acknowledge that the entire basis for the consideration of my request is DOH's voluntary participation and mission to increase the availability of primary medical care in areas designated by the Secretary of the U.S. Department of Health and Human Services as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs).
4. I understand and agree that in consideration for the granting of a waiver by the BCIS, I shall render medical care services to patients, including the underserved, for a minimum of forty (40) hours per week, not less than 50% of the hours will be providing primary medical care, within a designated HPSA or MUA in Florida. Such service shall commence not later than 90 days after I receive notification of approval by the BCIS and shall continue for a minimum of three years.
5. I agree to provide health services to individuals without discriminating against them because (a) they are unable to pay for those services or (b) payment for those health services will be made under Medicaid or Medicare. I will charge persons receiving services at the usual and customary rate prevailing in the HPSA or MUA in which services are provided, except persons at or below 200 percent of the federal poverty level as determined annually by Department of Health and Human Services shall be charged on a discounted or sliding fee schedule or shall not be charged if they are unable to pay for these services.
6. I expressly agree to provide written notification of the specific location and nature of my practice to DOH at the time I receive notification of the granting of the waiver from BCIS and at the time I commence rendering services in the HPSA or MUA. I further understand and agree that relocation from a site approved in the application request to a different site must be approved by DOH in writing prior to the relocation.

7. I agree to comply with the requirements set forth in Section 214(k) of the Immigration and Naturalization Act and to comply with all DOH J-1 Visa Program Monitoring and Reporting Requirements.

8. I also declare and certify, under penalty of the provisions of 18 U.S.C. 1001, that I do not now have pending nor am I submitting during the pendency of this request to any U.S. department or agency or any state department of public health, or equivalent agency, other than DOH, to act in any matter relating to a waiver of the foreign residency requirement set forth in my J-1 Visa.

9. I further certify that my prospective employer will structure my employment and the operations of the health care facility to facilitate my compliance with the requirements of my waiver, if granted.

**FURTHER AFFIANT SAYETH NAUGHT.**

\_\_\_\_\_

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_

Notary Public

My commission expires:

Florida Department of Health

**APPLICATION FOR  
J-1 VISA WAIVER PROGRAM**

Please check appropriate box:

Full-time Primary Care       Primary and Specialty Care       Full-time Specialist

EMPLOYER (HEALTH CARE FACILITY)

ADDRESS	CITY	ZIP	COUNTY
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CONTACT PERSON	TELEPHONE #	FAX #	EMAIL
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CLINIC WHERE J-1 PHYSICIAN WILL PRACTICE (if different from above.) PLEASE LIST ALL LOCATIONS, IF MORE THAN ONE

NAME OF J-1 PHYSICIAN	HOME COUNTRY	DATE OF BIRTH
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PRIMARY CARE SPECIALTY	SUBSPECIALTY
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**Documentation Required:** Include J-1 physician's curriculum vitae/resume.

**SITE DATA**

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

- For-Profit     Non-Profit     Government Organization     Federally Qualified Health Center
- Community Mental Health Center     Public Hospital Outpatient Clinic     Health Department
- University-Based Outpatient Clinic     Homeless Clinic     Other (*Specify*) \_\_\_\_\_

Provide the total number of active patients at the practice site in the previous calendar year with totals, as applicable, for primary care, specialty care and mental health services.

Primary Care	Specialty Care	Mental Health Care	Total

Total users in previous calendar year below 200% of the Federal Poverty Level \_\_\_\_\_

Provide a breakdown of each of the following payor types by patient group.

Group	Medicaid	Medicare	Sliding Fee/ Self-Pay	Commercial	No Pay/ Write-Off
Pediatric/ Adolescent					
Adult					
Geriatric					

**Documentation Required:** Submit a report or other documentation that supports the information provided above. INCLUDE MEDICAID PROVIDER NUMBER. Florida's guidelines require that the health care facility serve Medicaid, low-income and uninsured clients. If this position will be filled in a new location/expansion of the existing facility, use the data from the existing facility.

Does the health care facility have an existing discounted/sliding fee schedule?  Yes  No

If yes, does the health care facility have a notice conspicuously posted of the availability of a discounted/sliding fee schedule?  Yes  No

If no, does the health care facility agree to implement a discounted/sliding fee schedule, as well as post the notice of availability?  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. 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. Samples are available on our website: [www.doh.state.fl.us/recruit](http://www.doh.state.fl.us/recruit)

What is the minimum fee charged for an office visit? \_\_\_\_\_

Current Staffing Levels. List staff specific to the **facility** where the physician will be providing services..

AREA OF PRACTICE	NAME	% OF TIME AT CLINIC
<b>PRIMARY CARE PHYSICIANS</b>		
Family Practice		
General Internal Medicine		
General Pediatrics		
Obstetrics/Gynecology		
Psychiatry		

SPECIALIST PHYSICIANS (Please specify specialty area)		

Proposed J-1 physician weekly work schedule *(Provide schedule for each clinic location)*

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

Is the J-1 physician fluent in Spanish?  Yes  No

Does the employment contract contain a non-compete clause?  Yes  No

Is the **employer** a current member of a local volunteer program?  Yes  No

List: \_\_\_\_\_

Is salary **fixed**, or based primarily on **productivity**? (circle one)

**NEEDS ASSESSMENT**

Describe how a J-1 physician will be used to meet the underserved population needs in the service area. Indicate if unique qualifications, such as language/cultural match or experience with a population similar to those in the service area, are sought to meet a particular need.

Provide statistics demonstrating the specialty/sub-specialty is greatly needed in the sponsoring site's service area.

Document that the specialty/subspecialty is not currently available to sufficiently meet the need in the service area for the underserved population.

**COMMUNITY INVOLVEMENT**

Provide a description of facility's involvement with other community safety-net providers (health department, community health center, etc.) Please provide letters of support from these providers, indicating specific efforts of coordination/cooperation.

Does facility participate with a county or local volunteer program that provides clinical care? Please explain services.

***If this application is for a full-time specialist or for a Non-HPSA-MUA/P (FLEX) waiver, please complete the appropriate addendum.***

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 one completed application.***

## **SPECIALIST WAIVER ADDENDUM**

Applicants submitting an application for a specialist waiver must demonstrate a need for that physician specialty. Need is to be demonstrated by sufficient documentation that indicates the specialty is critical to the delivery of services in the community, the specialist is in high demand and the specialist will serve the needs of the community's Medicaid, Medicare and uninsured populations. *Demonstrate a need for the specialty by addressing one of the following three need criteria:*

- 1) The physician specialty is needed to address a major health problem in the facility service area.
  - a) Identify the health problem and how this specialty will address it.
  - b) Provide data on the number of patients affected and how many are low-income (Medicaid) or uninsured.
  - c) If this specialty is not available in the community, identify the nearest location where this specialty service can be obtained.

OR

- 2) The physician specialty is needed to address population-to-physician ratio because the current ratio does not meet national standards.
  - a) Provide the population-to-physician ratio for the specialty, include source for data provided.
  - b) Provide the number of physicians (FTE) practicing this specialty in the same health professional shortage area/facility service area.
  - c) Provide the distance to the nearest physician practicing the same specialty.
  - d) Describe how the demand for the specialty has been handled in the past.

OR

- 3) The physician specialty is needed to meet state or federal health care facility regulations, for example to maintain the hospital trauma designation level.
  - a) Identify the regulation, and
  - b) Address how the facility is currently meeting this regulation.

## **NON-HPSA-MUA/P (FLEX) WAIVER ADDENDUM**

*Applicants submitting an application for a Non-HPSA-MUA/P waiver must demonstrate a need by addressing the following need criteria:*

- 1) Provide evidence that a minimum of 30% of the employer's current patient base resides in a neighboring HPSA or MUA/P.
- 2) Provide evidence the facility serves a disproportionate share of uninsured and/or Medicaid recipients (data on the number of patients affected and how many are low-income or uninsured).
- 3) If this service is not available in the community, identify the nearest location where this service can be obtained.

**J-1 VISA WAIVER APPLICATION  
CRITERIA/SCORING METHODOLOGY**

<b><u>CRITERIA/REVIEW ELEMENT</u></b>	<b><u>POSSIBLE POINTS</u></b>
<b><u>REQUIRED CRITERIA</u></b>	<b>0</b>
<ul style="list-style-type: none"> <li>• Clinic located in a HPSA, MUA or MUP</li> <li>• J-1 physician board certified/eligible in the U.S. in a primary care specialty</li> <li>• 40 hour/week outpatient; 100% primary care or minimum 20 hours primary care; maximum 20 hours specialty care</li> <li>• Must agree to serve Medicaid, utilize sliding fee, post notice</li> </ul>	
<b><u>NEEDS ASSESSMENT</u></b>	<b>18</b>
<ul style="list-style-type: none"> <li>• HPSA Designation Score (High-5/Medium-3/Low-1)</li> <li>• Statutory Rural County</li> <li>• Physician to Patient Ratio &gt; 2000</li> </ul>	1-5 8 5
<b><u>COMMUNITY INVOLVEMENT/INPUT</u></b>	<b>30</b>
<ul style="list-style-type: none"> <li>• Support letters</li> <li>• Employer's involvement w/safety-net providers</li> <li>• Volunteer services</li> </ul>	1-10 1-10 1-10
<b><u>SITE DATA</u></b>	<b>35</b>
<ul style="list-style-type: none"> <li>• Patient mix: Medicaid, Sliding Fee (&gt; 30%)</li> <li>• Safety-net provider (see guidelines)</li> </ul>	15 20
<b><u>OTHER FAVORABLE CRITERIA</u></b>	<b>42</b>
<ul style="list-style-type: none"> <li>• Contract does not contain non-compete clause</li> <li>• Minimum fee for service is &lt;=\$20</li> <li>• J1 fluent in Spanish</li> <li>• 100% primary care</li> <li>• Employer is current member of local volunteer program</li> <li>• Medicare patients are &lt; 50% of total patient mix</li> <li>• Annual fixed base salary</li> </ul>	10 8 8 6 6 2 2

**STATE 30/J-1 VISA WAIVER APPLICATION  
CRITERIA/SCORING METHODOLOGY  
FULL-TIME SPECIALISTS**

<b><u>CRITERIA/REVIEW ELEMENT</u></b>	<b><u>POSSIBLE POINTS</u></b>
<b><u>REQUIRED CRITERIA</u></b>	<b>0</b>
<ul style="list-style-type: none"> <li>• Clinic located in a HPSA, MUA or MUP</li> <li>• 40 hours/week patient care</li> <li>• Must agree to serve Medicaid, Medicare, low-income population</li> </ul>	
<b><u>NEEDS ASSESSMENT</u></b>	<b>40</b>
<ul style="list-style-type: none"> <li>• Demonstrated Need for Specialty (see Specialist Waiver Addendum) <span style="float: right;">10-30</span></li> <li>• Statutory Rural County or Specialty Physician Scarcity Area (PSA) <span style="float: right;">10</span></li> </ul>	
<b><u>COMMUNITY INVOLVEMENT/INPUT</u></b>	<b>30</b>
<ul style="list-style-type: none"> <li>• Support letters (from Safety-Net Providers) <span style="float: right;">1-10</span></li> <li>• Employer's involvement w/safety-net providers <span style="float: right;">1-10</span></li> <li>• Volunteer services <span style="float: right;">1-10</span></li> </ul>	
<b><u>SITE DATA</u></b>	<b>35</b>
<ul style="list-style-type: none"> <li>• Patient mix: Medicaid, Sliding Fee (&gt; 30%) <span style="float: right;">15</span></li> <li>• Safety-net provider: (see guidelines) <span style="float: right;">20</span></li> </ul>	
<b><u>OTHER FAVORABLE CRITERIA</u></b>	<b>30</b>
<ul style="list-style-type: none"> <li>• Contract does not contain non-compete clause <span style="float: right;">10</span></li> <li>• Employer is current member of local volunteer program <span style="float: right;">10</span></li> <li>• Referral system in place that includes affiliation agreements with other health care entities, specifically safety-net providers <span style="float: right;">10</span></li> </ul>	

**STATE 30/J-1 VISA WAIVER APPLICATION  
CRITERIA/SCORING METHODOLOGY  
NON-HPSA-MUA/P (FLEX)**

<b><u>CRITERIA/REVIEW ELEMENT</u></b>	<b><u>POSSIBLE POINTS</u></b>
<b><u>REQUIRED CRITERIA</u></b>	<b>0</b>
<ul style="list-style-type: none"> <li>• 40 hours/week clinical care</li> <li>• Must agree to serve Medicaid, Medicare, low-income population</li> </ul>	
<b><u>NEEDS ASSESSMENT</u></b>	<b>100</b>
<ul style="list-style-type: none"> <li>• County does not have an FQHC</li> <li>• Surrounding designated areas have a HPSA score of 14 or above</li> <li>• Physician to Patient Ratio &gt; 2000</li> <li>• Demonstrated Need for Non-HPSA/MUA placement (see Non-HPSA/MUA Waiver Addendum)</li> <li>• Demonstrated Need for Specialty (see Specialist Waiver Addendum)</li> <li>• Statutory Rural County or Specialty Physician Scarcity Area (PSA)</li> </ul>	10 10 10 10-30 10-30 10
<b><u>COMMUNITY INVOLVEMENT/INPUT</u></b>	<b>30</b>
<ul style="list-style-type: none"> <li>• Support letters (from Safety-Net Providers)</li> <li>• Employer's involvement w/safety-net providers</li> <li>• Volunteer services</li> </ul>	1-10 1-10 1-10
<b><u>SITE DATA</u></b>	<b>35</b>
<ul style="list-style-type: none"> <li>• Patient mix: Medicaid, Sliding Fee (&gt; 30%)</li> <li>• Safety-net provider: (see guidelines)</li> </ul>	15 20
<b><u>OTHER CRITERIA</u></b>	<b>30</b>
<ul style="list-style-type: none"> <li>• Contract does not contain non-compete clause</li> <li>• Employer is current member of local volunteer program</li> <li>• Referral system in place that includes affiliation agreements with other health care entities, specifically safety-net providers</li> </ul>	10 10 10

Florida Department of Health  
J-1 Visa Waiver Program  
**Annual Report**

Reporting Period: From: \_\_\_\_\_ To: \_\_\_\_\_

PHYSICIAN	PRIMARY CARE SPECIALTY	SUBSPECIALTY
EMPLOYMENT START DATE	ANNUAL SALARY	PRACTICE COUNTY
MEDICAID PROVIDER #:		MEDICARE PROVIDER #:
EMPLOYER NAME (if more than one location, provide information for each)		
ADDRESS	CITY	ZIP
TELEPHONE #	FAX #	

Practice Type:     CHD     FQHC/CMHC     Private Practice  
 Hospital/University Clinic     Other (Specify) \_\_\_\_\_

Enter daily office hours (include administrative time, do not include time spent on call)

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

Average hours worked per week at clinical practice:  Primary Care      
Specialty Care

Average hours worked per week at hospital:

Number of total patient visits (office visits only) by source of payment:

Medicare	Sliding Fee	
Medicaid	Self Pay	
Full-Pay & Commercial Insurance	No Pay	
Other	TOTAL	

Is a notice posted in a conspicuous manner in your waiting room stating that a discounted/sliding fee schedule is employed by your practice and that patients will be treated regardless of their ability to pay?  Yes  No

Number of users who applied for discounted/sliding fee eligibility:

Number of users who were approved for discounted/sliding fee eligibility:

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**J-1 Physician Certification:** I hereby acknowledge that all information and statements contained herein are true and do not misrepresent fact. I further acknowledge that I have complied with the requirements of the J-1 Visa Waiver Program.

\_\_\_\_\_  
J-1 Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
J-1 Physician Name (PRINTED)

**Employer Certification:** I hereby acknowledge that all information and statements contained herein are true and do not misrepresent fact. I further acknowledge that I have complied with the requirements of the J-1 Visa Waiver Program.

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer Name (PRINTED)

\_\_\_\_\_  
Title

RETURN COMPLETED REPORT **AND** A COPY OF **CURRENT** DISCOUNTED/SLIDING FEE SCHEDULE TO:

Department of Health  
J-1 Visa Waiver Program  
Office of Health Professional Recruitment  
4052 Bald Cypress Way, Bin C-15  
Tallahassee, Florida 32399-1735  
(850) 922-6296 (FAX)