

OREGON J-1 VISA WAIVER EMPLOYMENT VERIFICATION FORM

Reporting period from _____ to _____

(Please report for the full amount of time at the sponsoring facility)

Physician's Name: _____

Street Address

City

State

ZIP

Home Phone No: (____) _____

BCIS Approval Date or Employment Start date, whichever is later _____

1. I maintain a full-time clinical practice at (If more than one address, please attach separate sheet):

Name of Medical Practice: _____

Street Address: _____

City/State/ZIP: _____

Telephone Number: (____) _____

2. During the reporting period, I maintained office hours (use "X" for day not usually practicing). DO NOT include "on call" status time.

	Sun	Mon	Tues	Wed	Thurs.	Fri	Sat
From:							
To:							

1. During the reporting period, approximately _____ hours/week were required to treat hospital patients of the practice at _____ Hospital.
2. During the reporting period, I was absent from the practice for _____ days due to illness, vacation, or for continuing professional education.
3. For this reporting period:
- a. Number of office visits* (do not include telephone consultations): _____
 - b. Number of total uninsured, low income patients (those at or below 200% of the Federal Poverty Level) who received services at a rate less than usual customary fee _____
 - c. Number of patient visits for which a Medicaid claim was submitted _____
 - d. Number of patient visits for which a Medicare claim was submitted _____
 - e. Source of data (verifiable by DHS audit) _____

CERTIFICATION

I CERTIFY THAT THE INFORMATION REPORTED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND ACURATELY REFLECTS ACTIVITIES RELATED TO THE CONRAD PROGRAM.

Physician's Name (Print or Type)

Date

Physician's Signature

EMPLOYER ENDORSEMENT

I HAVE REVIEWED THE ABOVE REPORT SUBMITTED BY _____, WHO BEGAN HIS/HER PRACTICE WITH US ON _____. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IS ACCURATE AND CORRECT.

Signature: _____

Date: _____

Title: _____