

# OREGON CONRAD VERIFICATION OF EMPLOYMENT FORM

Reporting period from \_\_\_\_\_ to \_\_\_\_\_

(Please report each six month period separately during the contract duration)

Physician's Name: \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

ZIP \_\_\_\_\_

Home Phone No: (\_\_\_\_) \_\_\_\_\_

Employment Start date \_\_\_\_\_

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 patient contacts \* (do not include telephone consultations): \_\_\_\_\_
  - b. Number of totally 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 visits for which a primary or secondary Medicaid claim was submitted: \_\_\_\_\_
  - e. Source of data (verifiable by DHS audit) \_\_\_\_\_

\*do not include hospital visits unless physician's practice is inpatient-based (e.g. hospitalist, anesthesiologist)

## 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: \_\_\_\_\_