

OREGON J-1 VISA WAIVER EMPLOYMENT STATUS FORM

Reporting period from _____ to _____

(Please report each six-month period separately during the first three years at the sponsoring facility)

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 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\Medicaid claim submitted (Including Dual Eligibles) _____
 - d. Number of patient visits\Medicare claim submitted (Not including Dual Eligibles) _____
 - e. Source of data (verifiable by OHPPR audit) _____

CERTIFICATION

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

Physician's Name (Print or Type)

Date

Physician's Signature

EMPLOYER ENDORSEMENT

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

Signature: _____

Date: _____

Title: _____