

# 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 self-pay, low income patient visits (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: \_\_\_\_\_