PHYSICIAN 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: _______________________________ Email: _______________________________

Phone: _______________________________ Employment Start Date: _________________________

If this is a final report, is physician staying with your facility after the 3-year end date? ______________

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

Name of Medical Practice: ____

Practice Address: ____

City/State/ZIP: ____

During the reporting period I worked an average of _____ hours per month. I was absent a total of _____________ days due to illness, vacation or other leave.

1. For this reporting period (for the physician):
   - (a) Grand total of all patient encounters from all sources, not including telephone: ________________
   - (b) Number of self-pays, low-income patient encounters (at or below 200% of the Federal Poverty Level) who received services below the customary rate: ________________
   - (c) Number of Medicaid-eligible patient encounters, including Medicare dual eligible: ________________
   - (d) Number of Medicare-eligible patient encounters, including Medicare Advantage but not including those who are Medicare dual-eligible: ________________

   (Note: (a) also includes commercial insurance and self-pays above 200% FPL. It will always exceed the combined totals of (b), (c) and (d).
2. For this reporting period (for the facility) the percentage of all Medicaid-eligible patients: ______________
3. Source of data verifiable by OHA audit: ____

PHYSICIAN CERTIFICATION

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

Physician's Name (Print or Type): ____

Signature: ____ Date: ____________________

EMPLOYER ENDORSEMENT

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

Name (Print or Type): ____________________________ Title: ______________________________

Signature: ____ Date: ____________________

Return to: Dia Shuhart Oregon Primary Care Office 500 Summer St. NE, E-65 Salem, OR 97301 – or – dia.shuhart@dhsoha.state.or.us

OHA 8279L (06/22)