

## PHYSICIAN VISA WAIVER EMPLOYMENT STATUS FORM



### Reporting Period

**From:**

**To:**

*(Please report each year separately during the first three years at the sponsoring facility)*

### Physician Information

Name (first & last):

Email:

Phone:

Employment Start Date:

- If this is a final report, is physician staying with your facility after the 3-year end date? Check the box next to the answer.  
 Yes  No

### Clinical Practice

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

Name of Medical Practice:

City/State/ZIP:

## Reporting Period Information

1. During the reporting period I worked an average of \_\_\_\_\_ hours per month.
  
2. I was absent a total of \_\_\_\_\_ days due to illness, vacation or other leave.
  
3. 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 OHP (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/OHP dual-eligible:
  
4. For the facility, the percentage of all:
  - a. OHP-eligible patients:
  - b. Medicare patients:
  
5. 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 by mail or e-mail to:

**Dia Shuhart, Oregon Primary Care Office, 500 Summer St. NE, E-65 Salem, OR 97301** - or- [dia.shuhart@oha.oregon.gov](mailto:dia.shuhart@oha.oregon.gov)

Voice: (503) 373-0364 | All relay calls accepted

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*Note: (a) also includes commercial insurance and self-pays above 200% FPL. It will always exceed the combined totals of (b) (c) and (d).*