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)[i]:
   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: 0.00%
   b. Medicare patients: 0.00%

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@dhsoha.state.or.us**
Voice: (503) 373-0364 | All relay calls accepted

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