

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. Grand total of all patient visits from all sources (do not include telephone consultations) _____*
 - b. Number of self-pay, low income patient visits (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) _____

*Note: a, which includes commercial insurance and self pay above 200% FPL, will always exceed the total of b, c and d.

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)

 Date

 Physician's Signature

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.

Signature: _____ Date: _____

Title: _____