

OREGON J-1 VISA WAIVER EMPLOYMENT VERIFICATION FORM

Reporting period from _____ to _____
(Please report for the full amount of time at the sponsoring facility)

Physician's Name: _____

Street Address _____

City State ZIP

Home Phone No: () _____

BCIS Approval Date or Employment Start date, whichever is later _____

- 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.

Table with 8 columns: Sun, Mon, Tues, Wed, Thurs., Fri, Sat. Rows: From: (blank), To: (blank)

- 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 total uninsured, low income patients (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 for which a Medicaid claim was submitted _____
d. Number of patient visits for which a Medicare claim was submitted _____
e. Source of data (verifiable by DHS audit) _____

CERTIFICATION

I CERTIFY THAT THE INFORMATION REPORTED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND ACURATELY REFLECTS ACTIVITIES RELATED TO THE CONRAD PROGRAM.

Physician's Name (Print or Type) _____

Date _____

Physician's Signature _____

EMPLOYER ENDORSEMENT

I HAVE REVIEWED THE ABOVE REPORT SUBMITTED BY _____, WHO BEGAN HIS/HER PRACTICE WITH US ON _____. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IS ACCURATE AND CORRECT.

Signature: _____ Date: _____

Title: _____