

This cover sheet must be completed by all practice sites proposing to employ physicians under the New York "State 30" J-1 Visa waiver program. Please complete and mail, along with all other requested materials, to: New York State Department of Health, New York "State 30" Program, Corning Tower Room 1695, Albany, New York 12237 (Phone: 518-473-4700).

Please print clearly or type.

I. IDENTIFYING INFORMATION – PHYSICIAN

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ ZIP

Phone Number -- E-mail _____@_____

Specialty _____

Home Country _____

Date of Birth -- USMLE/ECFMG ---

NYS Physician License # (If available)

II. ATTORNEY INFORMATION

Last Name _____ First Name _____ MI _____

Firm Name _____

Address _____

City _____ State _____ ZIP

Phone Number -- E-mail _____@_____

NPI # _____

III. PROPOSED PRACTICE SITE INFORMATION

Practice Site Name _____

Site Contact Last Name _____ First Name _____

Address _____

City _____ State _____ ZIP

Phone Number -- E-mail _____@_____

Sponsoring Agency (If different from Practice Site) _____

- Type of Site Hospital Diagnostic & treatment Center (Health Clinic) Private Practice
 Nursing Home Hospital Extension Clinic Correctional Facility
 Safety Net Hospital Other _____

IV. SERVICES TO THE MEDICALLY INDIGENT

The purpose of this section is to determine the amount of services that are, or will be, provided annually to medically indigent patients by the physician listed in Section I at the worksite listed in Section III.

Please estimate the number of patient visits, by source of payment, for the actual physician listed in Section I for the most recent 12-month period for which data is available. Indicate the 12-month period below.

If the physician for whom the waiver is requested is NOT currently employed at the site listed in Section III, please estimate visit data based on visits provided by one currently or recently-employed physician practicing in a similar specialty at the site listed in Section III. **IF THAT IS NOT POSSIBLE, THEN** estimate visits provided by one currently or recently-employed physician practicing in a similar specialty at another similar site.

INCLUDE PATIENT VISITS FOR THE PHYSICIAN ONLY; DO NOT LIST ALL VISITS FOR THE SITE OR FACILITY. Please answer questions 1-3 as accurately and specifically as possible.

Source of Payment	Number of Visits to Physician
1. MEDICAID (e.g., Medicaid, Medicaid FFS, Medicaid Managed Care, HMO/PHSP Medicaid, including Child Health Plus and Family Health Plus)	
2. PARTIAL SELF-PAY or FREE (e.g., Sliding Scale, Partial Fee or Free)	
3. ALL OTHERS (e.g., Medicare, Medicare Managed Care, Commercial, Other Managed Care, Workers Compensation, No-fault, Government, Blue Cross/Blue Shield, HMO/PHSP, Full Self-Pay, Other)	
4. TOTAL 1+2+3=	

CHECK ONE

- Visit data above refers to services provided by actual physician for which the waiver is requested.
- Visit data above refers to services provided by another physician in a similar specialty at the site listed in III above.
- Visit data above refers to services provided by another physician in similar specialty at another, similar site.

12-month period for above data: _____

Source/contact for above data: Name _____

Phone Number - -

1. Is the physician listed in Section I filling a vacant position at the site? Yes No

If yes, for how long was the position vacant? _____ months

2. Is the physician proposing to practice at least 40 hours per week in a HPSA or MUA? (Check one:)

Yes Indicate the HPSA/MUA/MUP name(s) below. *Ignore Section V.*

HPSA(s) _____

MUA/P(s) _____

No *Go to Section V.*

