FLORIDA PHYSICIAN NATIONAL INTEREST WAIVER
Request for Acknowledgement Letter of Work in the Public Interest

Only typed requests will be accepted.

SECTION 1 - Applicant Information

Name: Last:	First:	Middle:
NPI Number:	Email Address:	
FL Medical License Number:		
Country of Birth:	Country of Legal Permanent Residence:	
Gender: ☐ Female ☐ Male	DOB:	Current Address:

Practice Type **(select only one)**:

☐ Family Medicine ☐ Internal Medicine - General ☐ Pediatrics - General

☐ Obstetrics/Gynecology - General ☐ Psychiatry ☐ Specialty (specify: _____)

Did you/will you complete your residency program in the state of Florida? ☐ Yes ☐ No (specify state): _____

Do you plan to remain in the state of Florida after your NIW employment is over? ☐ Yes ☐ No

SECTION 2 - Immigration Attorney Information (if applicable)

Immigration Attorney Name:		
Immigration Firm Name (if applicable):		
Address:		
City:	State:	ZIP:
Contact Name (Other than attorney if applicable):		Telephone Number:
Email Address:		

If all of the required five (5) years of service in an underserved area (HPSA or MUA/P) was/will be with one employer, complete just this form. If the required five (5) years of service in an underserved area was with multiple employers, please complete an Additional Employment Information form for each employer to cover the entire 5-year period.

SECTION 3 - Employer Information

Employer Name:				
Address:				
City:	State:	ZIP:	County:	SELECT COUNTY
Contact Name:		Telephone Number:		
Email Address:				
Please Check One:	☐ For Profit	☐ Non-Profit	☐ Government Entity	☐ Other (specify:)

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SECTION 4 - Employment Information

The beginning date of employment with this employer:
The ending date of employment with this employer/ending date of required work time frame (can be a future date):
Does/Did the facility or practice sponsoring the physician agree to provide health services to individuals without discriminating against them because: (a) they were unable to pay for those services or (b) payment for those health services will be made under Medicare and Medicaid, or a state equivalent indigent health care program (including KidCare)? ☐ Yes ☐ No
Does/Did the facility provide care on a sliding fee payment arrangement for uninsured, low-income patients and is/was this notice publicly posted in the facility? ☐ Yes ☐ No

SECTION 5 - Practice Location Information

If there are more than three site locations, they must be submitted on a separate sheet. All location information must be included.

Primary Practice Site Location of Physician				
Facility/Practice Name:				Weekly Hours:
Address:				
City:	State:	ZIP:	County: SELECT COUNTY	
Contact Name:		Contact Phone:		
HPSA ID Number:	HPSA Name:		HPSA Score:	
If not in a HPSA: MUA/P Service Area Name:			MUA/P Number:	
The majority of patients are:	☐ Inpatient	☐ Outpatient	☐ Other (specify:)	

Secondary Practice Site Location of Physician				
Facility/Practice Name:				Weekly Hours:
Address:				
City:	State:	ZIP:	County: SELECT COUNTY	
Contact Name:		Contact Phone:		
HPSA ID Number:	HPSA Name:		HPSA Score:	
If not in a HPSA: MUA/P Service Area Name:			MUA/P Number:	
The majority of patients are:	☐ Inpatient	☐ Outpatient	☐ Other (specify:)	

Tertiary Practice Site Location of Physician				
Facility/Practice Name:				Weekly Hours:
Address:				
City:	State:	ZIP:	County: SELECT COUNTY	
Contact Name:		Contact Phone:		
HPSA ID Number:	HPSA Name:		HPSA Score:	
If not in a HPSA: MUA/P Service Area Name:			MUA/P Number:	
The majority of patients are:	☐ Inpatient	☐ Outpatient	☐ Other (specify:)	

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SECTION 6 - Payer Mix Your Grand Total cannot exceed 100%.

Provide a breakdown of each payer type by the patient group for the employer for the previous calendar year.

	Sliding Fee/ Charity Care	*Medicaid* (including dual eligible)	*Medicare Only*	*Private Insurance/Other*	*Total*
Pediatric (<18)	%	%	N/A	%	0.00 %
Adult (>18)	%	%	%	%	0.00 %
				GRAND TOTAL	0.00 **%**

Your Grand Total is less than 100%. Please update your percentages.

SECTION 7 - Attestations

I hereby attest that all information and statements contained herein are true and do not misrepresent facts. I further attest that I have not evaded or suppressed any information contained in this request form. This includes all Additional Employment Information forms or additional practice location information on separate pages. The information I have supplied on this application is complete, true, and accurate. To the best of my knowledge and belief, I am eligible for this program.

Applicant's Signature _____ Date _____ Applicant's Printed Name _____

Print Form

NOTICE: Any person who knowingly makes a false statement or misrepresentation on this form is subject to penalties under section 837.06, Florida Statutes, which may include fines, imprisonment, or both.