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's Name: _____ Email: _____

Phone: _____ Employment Start Date: _____

If this is a final report, is physician staying with your facility after the 3-year end date? _____

I maintain a full-time clinical practice at (if more than one address, please attach separate sheet):

Name of Medical Practice: _____

Practice Address: _____

City/State/ZIP: _____

During the reporting period I worked an average of _____ hours per month. I was absent a total of _____ days due to illness, vacation or other leave.

1. For this reporting period (for the physician):
   (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 dual-eligible: _____

   (Note: (a) also includes commercial insurance and self-pays above 200% FPL. It will always exceed the combined totals of (b), (c) and (d).
2. For the facility, the percentage of all: OHP-eligible patients:_____; Medicare patients: _____
3. 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 to: Dia Shuhart Oregon Primary Care Office 500 Summer St. NE, E-65 Salem, OR 97301 – or – dia.shuhart@dhsoha.state.or.us