



Maryland

DEPARTMENT OF HEALTH

Maryland J-1 Visa Waiver Program Site Application

1. Name of Practice _____

2. Street Address w/zip code *and County* where the Physician **will practice**:

3. Please check applicable: This site is a:

FQHC

Hospital

Private Practice

Other

If other, please specify _____

4. Contact Person: _____

Contact Person's Phone: _____ Ext. _____ Fax _____

Contact Person's Email _____

5. Name of Physician applying for J-1 Visa Waiver _____

Physician's Specialty _____

6. Is the Physician currently working at the Site? _____

7. How many hours of the week will the physician be working at the site? _____

8. Number of Full-time Equivalent Providers at the Site:

Family Practice:

Internal Medicine:

Pediatrician:

OB/GYN:

Nurse Practitioner:

Geriatrics:

Physician Assistant:

Psychiatrist:

Other (Please specify) _____

9. If applicable, number of current J-1 Visa Waiver physicians at this site? _____
10. How long has the position been vacant? _____
11. Does the Practice reduce fees for low-income persons who have limited ability to pay? _____
12. What **specific need** will the Physician meet? _____
13. How will this Physician improve the Practice and the community? (*Use additional sheets if necessary.*)
- _____
- _____
- _____
- _____

14. Please list the number of persons served by the practice site where the J-1 Physician will practice for the most recent year for which complete data are available:

	<u>Number</u>	<u>Percentage</u>
Medicaid	_____	_____
Medicare	_____	_____
Commercial Insurance	_____	_____
Uninsured Self-Pay	_____	_____
Sliding Fee (100% Self Pay, Above 200% Poverty)	_____	_____
Other (Underinsured or No Insurance, Below 200% Poverty)	_____	_____
Total	_____	_____

Additional Comments

PLEASE ATTACH

- 1. Background information about the practice.**
- 2. A copy of the site's brochure or marketing material if available.**
- 3. A copy of the site's Sliding Fee Scale and Sliding Fee Scale Policy.**
- 4. A copy of the posted public notice at the practice site, which indicates a Sliding Fee Scale, is in effect.**

Physician's Signature: _____ Date: _____

Employer's Signature: _____ Date: _____

Submit to:

Health Care Workforce Development
Office of Population Health Improvement
Maryland Department of Health
mdh.providerworkforceprograms@maryland.gov