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:

	Number	**Percentage**
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
201 West Preston Street
Baltimore, MD 21201
Phone: 410-767-6123
Fax: 410-333-7501
mdh.providerworkforceprograms@maryland.gov