



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