



Bureau of Health Planning
Division of Health Professions Development

VERIFICATION OF EMPLOYMENT & PRACTICE SITE PATIENT REPORT

File # \_\_\_\_\_

PART 1
TO BE COMPLETED BY PHYSICIAN

Report Period: Months: \_\_\_\_\_ thru \_\_\_\_\_, 20\_\_

Physician's Name \_\_\_\_\_ Cell/Home Telephone \_\_\_\_\_
(Area Code) Number

Medical Assistance Provider Number: \_\_\_\_\_ PA Medical License #: \_\_\_\_\_

Home Address \_\_\_\_\_

Number and Street City State Zip Code

Email Address: \_\_\_\_\_ Date J-1 Visa was waived: \_\_\_\_\_

H1B1 Visa Approval Date: \_\_\_\_\_ Start Date at practice site: \_\_\_\_\_

LOCATION OF MEDICAL PRACTICE \_\_\_\_\_

Name of Practice

Number and Street City Zip Code

TELEPHONE NUMBER OF PRACTICE SITE \_\_\_\_\_ Fax #: \_\_\_\_\_
(Area Code) Number

DAYS AND HOURS AT PRACTICE SITE: \_\_\_\_\_

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

HPSA/MUA/MUP \_\_\_\_\_

Name and Number

County

Was there any period of time during this six month reporting period that you were not providing services for 40 hours each week at your approved practice site? [ ] NO [ ] YES If yes, provide a detailed explanation (attach additional pages if necessary):

Are you working with a State Health Improvement Plan (SHIP) affiliated Health Improvement Partnership in your community? [ ] YES [ ] NO If yes, please attach a brief statement that provides the name of the Partnership and your involvement during this reporting period.

I hereby certify that the above information, and any attached statement, is complete and accurate, and that I, the undersigned, do provide health care services at the above stated practice and address a minimum of 40 hours per week. (If you are practicing at more than one site, attach a form for each site indicating the days and hours at each site.) I also certify that I will report to the Department of Health any proposed change in my original practice site and schedule. I make these written statements subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities.

Physician's Signature

Date

**PART 2**  
**TO BE COMPLETED BY PRACTICE SITE SPONSOR**

**PATIENT VISIT REPORT:**

Provide the number of **patient visits** in each of the following categories for each month during this six month period. Medicaid HMO patient visits should be reported under Medicaid. The data reported should be data that is related to the practice specialty of the waiver physician that is being supported. However, **the data should reflect all visits for this specialty**, not just the visits for the waiver physician. For example, if this is a waiver for a neurologist at Hospital XYZ, all patient visits for neurology at Hospital XYZ, regardless of who the provider of service was, should be reported for each month. **If physician is approved for multiple sites, a separate form must be submitted for each site.**

CATEGORY	Month: Year:	Month: Year:	Month: Year:	Month: Year:	Month: Year:	Month: Year:	6 Month Total
Medicare							
Medicaid							
Sliding/Discounted Fee Scale							
No Pay/No Fee							
Commercial/ HMO/Full Pay							
<b>TOTAL</b>							

**PART 3:**  
**TO BE CERTIFIED BY PRACTICE SITE SPONSOR**

*I hereby certify that all information and data submitted on this form by the Waiver Physician and Practice Site, and any attached statement, is complete and accurate. (A separate form must be submitted for each approved practice site.) I also certify that I will report to the Department of Health any proposed changes in employment status, practice site location or schedule. I make these written statements subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities.*

Sponsor's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Sponsor's Printed Name \_\_\_\_\_ Telephone: \_\_\_\_\_

(Area Code)    Number

Fax #: \_\_\_\_\_ Email address: \_\_\_\_\_

This form must be submitted (either by fax or mail) to the PA DOH every six months during the physician's term of commitment. Failure to do so will result in the report of non-compliance with the requirements of the Waiver Program to the United States Citizenship and Immigration Services (USCIS).

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