ALABAMA J-1 PHYSICIAN PRACTICE STATUS REPORT

Revised July 2014 (Previous editions are obsolete and should not be used)

Applicable to Physicians With Approved J-1 Visa Waivers Under the Alabama State-30 and ARC Waiver Programs

This report is to be completed by each physician approved under Alabama's State-30 Visa Waiver Program or the Appalachian Regional Commission's (ARC) Visa Waiver Program. The report must be completed when the physician first starts work and each 6 months thereafter, until the physician completes his/her 3-year waiver service obligation.

Please type or print all entries except signatures.

PART 1 - TO BE COMPLETED BY REPORTING PHYSICIAN:

Physician's Name: _____ _____ _____
(First Name) (Middle Initial) (Last Name)

Type Service (Circle One): Primary Care Clinical Practice *Primary Care Emergency Department

Psychiatrist *Sub-specialist in _____(*Not Applicable to ARC)

During this report period, I have practiced medicine at a total of _____ practice sites, as named below.

Practice Site(s): _____
(Practice Site(s) Name)

Practice Address(es) During Report Period: (If additional practice sites, list on separate sheet of paper) _____
(Street)

_____ _____ _____ _____ - _____
(City) (County) (State) (Zip Code)

Practice Telephone #(s): _____ - _____ -_____ **Email Address:** _____

Report Number (circle one):

Initial Report:	**I began practicing at this location(s) on (insert date): _____**
6 Month Report:	**I have been practicing at above location(s) for 6 months, from _____ to _____**
7 - 12 Month Report:	**I have been practicing at above location(s) for 7-12 months, from _____ to _____**
13 -18 Month Report:	**I have been practicing at above location(s) for 13-18 months, from _____ to _____**
19 - 24 Month Report:	**I have been practicing at above location(s) for 19-24 months, from _____ to _____**
25 - 30 Month Report:	**I have been practicing at above location(s) for 25-30 months, from _____ to _____**
Final Report:	**I have completed 31-36 months service at above location(s), from _____ to _____,**
31 - 36 Months	**and:**

__ ____ I intend to remain at this location

_____ I do not intend to remain at this location

My typical work schedule during this reporting period has been as follows: (Example of entry: From 8 AM to 5 PM, less 1 hour for meal break = 8 actual work hours.)

Monday:	**From**	**_____**	**to**	**_____**	**less _____ hour meal break**	**=**	**_____ actual in-clinic work hours**
Tuesday:	**From**	**_____**	**to**	**_____**	**less _____ hour meal break**	**=**	**_____ actual in-clinic work hours**
Wednesday:	**From**	**_____**	**to**	**_____**	**less _____ hour meal break**	**=**	**_____ actual in-clinic work hours**
Thursday:	**From**	**_____**	**to**	**_____**	**less _____ hour meal break**	**=**	**_____ actual in-clinic work hours**
Friday:	**From**	**_____**	**to**	**_____**	**less _____ hour meal break**	**=**	**_____ actual in-clinic work hours**
Saturday	**From**	**_____**	**to**	**_____**	**less _____ hour meal break**	**=**	**_____ actual in-clinic work hours**
Sunday	**From**	**_____**	**to**	**_____**	**less _____ hour meal break**	**=**	**_____ actual in-clinic work hours**

Total Hours Worked Each Week: _____

(**Continued on reverse**)

PART 1 - CONTINUED

The number of patients I have treated during this reporting period were as follows:

		Number	Percentage
a.	**Total number of patient visits (Sub-specialists should include all visits, but primary care physicians should not include telephone consultations or hospital visits)**	_____	**100 %**
b.	**Number of patient visits for whom a *Medicare* claim was submitted:**	_____	_____**%**
c.	**Number of patient visits for whom a *Medicaid* claim was submitted:**	_____	_____**%**
d.	**Number of patient visits wherein services were rendered at a rate less than the usual and customary fee under a sliding fee scale:**	_____	_____**%**
e.	**Number of patient visits for which no charge was made (based on inability to pay):**	_____	_____**%**
f.	**Number of patient visits covered by private insurance:**	_____	_____**%**
g.	**Number of uninsured, self-pay visits who paid full charges:**	_____	_____**%**
h.	**Number of patients who did not pay and inability to make further contact with patients**	_____	_____**%**

My *Medicare* Provider Number(s) is (are): _____

My *Medicaid* Provider Number(s) is (are): _____

Number of Alabama Medicaid Patient 1st participants which I have agreed to accept: _____

I hereby certify *under penalty of licensure action and possible revocation of my J-1 waiver* that I, the undersigned physician, personally delivered the type of healthcare services for which my J-1 waiver was approved at the above address at least 40 hours per week I further certify that my practice is using the sliding fee scale or 'no-pay' policy submitted with my waiver application for uninsured patients with household incomes at or below 200 percent of the Federal Poverty Level. All the information reported on this form is true to the best of my knowledge and belief.

_____ _____ _____ _____

(Physician's Signature) (Date) (Telephone #) (Email Address)

PART 2 - TO BE COMPLETED BY SPONSOR/EMPLOYER:

I hereby certify *under penalty of licensure action and other liability for fraudulent claims* that the information provided on this report is true and correct to the best of my knowledge and belief. I further certify that this organization uses the sliding fee scale or 'no-pay' policy submitted with the above J-1 physician's waiver application to discount payment fees for uninsured patients with household incomes at or below 200 percent of the Federal Poverty Level.

_____

Organization

_____ _____

Employer's Signature **Date**

_____ _____ - _____ - _____

Printed/Typed Name **Telephone Number**

_____ _____

Title **E-mail Address**

Please return this completed form to:

Alabama Department of Public Health
Office of Primary Care and Rural
Health ATTN: J-1 Program Manager
201 Monroe St., Suite 1040
P.O. Box 303017
Montgomery, AL 36130-3017
Email: J-1waiverInbox@adph.state.al.us

If you have questions regarding completion of this form, call: (334) 206-5396 or Fax: (334) 206-5434 or (334) 206-0340