



Gerd W. Clabaugh, MPA
Director

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Iowa J-1 Visa Waiver/Conrad 30 Annual Report

Physician's full name: _____

Employer's name: _____

Clinical Practice Site: _____

Practice site address(es): _____

Physician's Email Address: _____

Physician's Phone Number: _____

The following information is to be completed by the business office and/or the appropriate administrator. Please refer to the previous year of the physician's employment.

Table with 2 columns and 5 rows: Total number of patient encounters, Total number of Medicaid patient encounters, Total number of Medicare patient encounters, Total number of hawk-i (SCHIP) patient encounters, if applicable, Total number of uninsured patient encounters.

Time Period Covered by Report: _____ to _____

Is the physician currently working at least 40 hours per week in a designated health professional shortage area?

_____ YES _____ NO _____ NA (undesigned/flex waiver)

Does the physician regularly or intermittently provide services at a Federally Qualified Community Health Center or Free Clinic?

_____ YES _____ NO

If yes, what is the name of the facility?

Any additional information you would like to report?

Name and signature of individual completing report:

Name (printed)

Signature

Title

Date

If you have any questions regarding the Iowa J-1 Visa Waiver program please contact:

Primary Care Office
Bureau of Oral and Health Delivery Systems
Iowa Department of Public Health
321 E 12th Street
Des Moines, IA 50319-0075

Phone: 866-528-4020

Please submit report to:

Primary Care Office
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