



Semi-Annual Report Washington State J-1 Physician Visa Waiver Program

Reports are due every six months, beginning six months after the physician's start date of employment. Please complete this form and fax to our office at 360-236-2830, email a signed copy to Renee.Fullerton@doh.wa.gov, or mail to J-1 Visa Waiver Program, PO Box 47853, Olympia, WA 98504-7853.

Site Name _____

Street Address _____

City _____

State _____

Zip _____

Additional Sites _____

Street Address _____

City _____

State _____

Zip _____

Phone _____

Fax _____

Physician Name: _____

_____/_____/_____
Physician Start Date

Specialty

Languages other than English

Reporting Period (MM/DD/YY):

From ____/____ To ____/____

Enter regularly scheduled office hours (include administrative time):

Sunday: _____ Monday: _____ Tuesday: _____ Wednesday: _____

Thursday: _____ Friday: _____ Saturday: _____

Describe a typical work-week, including on-call schedule: _____



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Type of medical practice: _____

Medicare Provider Number

Medicaid Provider Number

1. Is your shortage area designation based on serving migrant farmworkers or the American Indian population?

Yes ⇒ Please provide number of total patient encounters with your targeted population: _____

No

2. Please check whether you accept the following and provide the number of total patient encounters (visits)* by source of payment: (*Include office, hospital, nursing home and home health visits.)

A) Medicare:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Do you accept assignment under Part B of Medicare as full payment for services?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If not, please explain:			
B) Medicaid:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
C) Reduced pay:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Please provide a copy of your sliding fee schedule.
D) No Pay:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Please provide a copy of your sliding fee schedule.
E) Full pay/Commercial Insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Total Number of patient visits: _____			

Physician's Signature

Employer's Signature and title