STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FORM DPH-1 Evidence of Current Shortage Area Designation

The Chief Administrator (Chief Administrative Officer/President/Administrator) of the health care facility shall complete the information required below and include this form with the application.

Name of Facility: _____ License No.: _____

Address: _____

_____

_____

Facility Census Tract No.: _____ Type of Shortage Area: _____
(i.e. Primary Care or Mental Health)

HPSA ☐ yes ☐ no Service Area Number, including Census Tract Numbers: _____

If population designation, please describe group: _____

MUA ☐ yes ☐ no Service Area Number, including Census Tract Numbers: _____

If population designation, please describe group: _____

MUP ☐ yes ☐ no Service Area Number, including Census Tract Numbers: _____

If population designation, please describe group: _____

Name of Foreign Medical Graduate: _____ Specialty: _____

Connecticut License No.: _____

Country of Origin: _____

********** (FOR OFFICE USE ONLY)********** *****

The Department of Public Health has determined that the facility referenced above is located in an area designated by the United States Department of Health and Human Services as a health professional shortage area.

_____ _____
Signature of Authorized Representative of BCH Date

Comments (Only required if the above IS NOT designated as a shortage area): _____

_____

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