Connecticut Conrad 30 / J-1 Visa Waiver Program

Monitoring Report Updates

This form is to be filled out accurately and submitted to the Connecticut Department of Public Health annually (every year) of the 3 required years of service of the J-1 Physician. To provide information beyond four work sites, please submit a new form with the additional sites.

Month and Year when Service Began: Report 1 (month and year) Report 2 Report 3

J-1 Physician Name

Contact Information Phone Fax Email

This section is required to complete only if there have been changes to this information since the physician's application was submitted to the CT DPH.

Employer Name
(If different from the practice site name)

Phone Fax Email

This section is required to complete only if there have been changes to this information since the physician's application was submitted to the CT DPH.

Practice Site Name

Address Town State Zip Code

HPSA ID

Contact Information Phone Fax Email

Area of Medicine Practice Setting

Did the physician work a full-time schedule throughout the entire service period, up to this date? Yes No* (*Please provide a separate explanation)

Is the physician working at more than one practice site? Yes No

If yes, please list:

Site Name	Site Address	Site Phone Number	Site HPSA ID

Number of hours per week J-1 physician provided direct patient care during this reporting period:

Number of days J-1 physician was absent due to leave of absence in excess† of accrued paid time off:

(†Please provide a separate explanation of the excess break in service.)

Number of unduplicated patients during this reporting period (NOT number of patient visits):

Total number of patients seen during this reporting period (number of patient visits):

Patient breakdown by primary payer source for this reporting period:

	Site #1		Site #2		Site #3		Site #4	
	Count	%	Count	%	Count	%	Count	%
a. Medicare								
b. Medicaid								
c. Private Insurance								
d. Self-Pay / No Insurance								
Total:		100%		100%		100%		100%

I hereby certify that I provided medical care services as described in this report and that all information contained in this report is true to the best of my knowledge and belief.

______________________________	______________
Signature of J-1 Physician	Date

I hereby certify that the aforementioned physician provided medical care services as described in this report and that all information contained in this report is true to the best of my knowledge and belief.

______________________________	______________________________
Employer Signatory (Type/Print Name)	Title
______________________________	______________
Signature of Employer	Date