OREGON CONRAD VERIFICATION OF EMPLOYMENT FORM

Reporting period from _____ to _____

(Please report each six month period separately during the contract duration)

Physician's Name: _____

_____
Street Address

_____
City State ZIP

Home Phone No: _(____)_____
Employment Start date_____

1. I maintain a full-time clinical practice at (If more than one address, please attach separate sheet):
   Name of Medical Practice: _____
   Street Address: _____
   City/State/ZIP: _____
   Telephone Number: _(____)_____

2. During the reporting period, I maintained office hours (use "X" for day not usually practicing). DO NOT include "on call" status time.

	Sun	Mon	Tues	Wed	Thurs.	Fri	Sat
From:							
To:							

1. During the reporting period, approximately _____ hours/week were required to treat hospital patients of the practice at _____Hospital.

2. During the reporting period, I was absent from the practice for _____ days due to illness, vacation, or for continuing professional education.

3. For this reporting period:
   a. Number of patient contacts * (do not include telephone consultations): _____
   b. Number of totally uninsured, low-income patients (those at or below 200% of the Federal Poverty Level) who received services at a rate less than usual customary fee: _____
   c. Number of visits for which a primary or secondary Medicaid claim was submitted: _____
   e. Source of data (verifiable by DHS audit) _____
   _____

*do not include hospital visits unless physician's practice is inpatient-based (e.g. hospitalist, anesthesiologist)

CERTIFICATION

I CERTIFY THAT THE INFORMATION REPORTED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND ACURATELY REFLECTS ACTIVITIES RELATED TO THE CONRAD PROGRAM.

_____ _____
Physician's Name (Print or Type) Date

_____
Physician's Signature

EMPLOYER ENDORSEMENT

I HAVE REVIEWED THE ABOVE REPORT SUBMITTED BY _____, WHO BEGAN HIS/HER PRACTICE WITH US ON _____. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IS ACCURATE AND CORRECT.

Signature: _____ Date: _____

Title: _____