pennsylvania
DEPARTMENT OF HEALTH

Updated: 7/1/2025

VERIFICATION OF EMPLOYMENT FORM

To Be Completed and Submitted by Practice Site

Please select one: **Select One** File # _____

Reporting Period: _____ thru _____ 20____

PHYSICIAN INFORMATON

Last Name: _____ First Name: _____ MI: _____

☐ **Check if this is a change of address from previous reports**

Home Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell/Home Phone #: _____ Email Address: _____

PRACTICE SITE

Name of Practice: _____

Street Address: _____

City: _____ County: _____ Zip code: _____

HPSA/MUA/MUP Name: _____ Number: _____

Supervisor's Name: _____

Phone: _____ Email: _____

Was there any period during this six-month reporting period that the physician was not providing service for 40 hours per week at the approved practice site? ☐ Yes ☐ No

If yes please explain:

Was there any period during this six-month reporting period that the physician was off without paid leave? ☐ Yes ☐ No

If yes please provide dates:

Pennsylvania Primary Care Office
Room 1031, Health & Human Services Building I 625 Forster Street I Harrisburg, PA 17120 I 717.772.5298
Email: waiverprograms@pa.gov

pennsylvania
DEPARTMENT OF HEALTH

Please Note: Time off without paid leave will be added to the end date of the waiver commitment

PATIENT VISIT REPORT:

Provide the number of **patient *visits*** in each of the following categories for each month during this six-month period. Medicaid HMO patient visits should be reported under Medicaid. The data reported should be data that is related to the practice specialty of the waiver physician that is being supported. However, **the data should reflect all visits for this specialty,** not just the visits for the waiver physician. For example, if this is a waiver for a neurologist at Hospital XYZ, all patient visits for neurology at Hospital XYZ, regardless of who the provider of service was, should be reported for each month. **If physician is approved for multiple sites, a separate form must be submitted for each site.**

Category	__/____	__/____	__/____	__/____	__/____	__/____
Medicare						
Medicaid						
Sliding/Discounted Fee Scale						
No Pay/No Fee						
Commercial/HMO/Full Pay						
Totals						

I hereby certify that all information and data submitted on this form by the Waiver Physician and Practice Site, and any attached statement, is complete and accurate. (A separate form must be submitted for each approved practice site.) I also certify that I will report to the Department of Health any proposed changes in employment status, practice site location or schedule. I make these written statements subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities.

Physicians Signature: _____ Date: _____

Sponsor's Signature: _____ Date: _____

Sponsor's Printed Name: _____ Telephone: _____

Sponsor's Email Address: _____

This form must be submitted (either by fax or mail) to the PA DOH every six months during the physician's term of commitment. Failure to do so will result in the report of non-compliance with the requirements of the Waiver Program to the United States Citizenship and Immigration Services (USCIS).

Pennsylvania Primary Care Office
Room 1031, Health & Human Services Building l 625 Forster Street l Harrisburg, PA 17120 l 717.772.5298
Email: waiverprograms@pa.gov