



### SEMIANNUAL REPORT

\_\_\_\_\_  
Reporting Period

**PHYSICIAN NAME:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**EMPLOYER NAME:** \_\_\_\_\_

Employer Point of Contact (Name, Title): \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**PRACTICE SITE NAME & ADDRESS(ES):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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

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

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

4) Patient breakdown by primary payer source for this reporting period (total should equal 100%):

- a. Medicare \_\_\_\_\_%
- b. Medicaid (include CHIP/PeachCare/CMOs) \_\_\_\_\_%
- c. Private Insurance \_\_\_\_\_%
- d. Self-Pay / No Insurance \_\_\_\_\_%

5) Number of self-pay patients utilizing sliding fee schedule during this reporting period: \_\_\_\_\_

6) Percentage of patients residing in the same county in which the practice site is located: \_\_\_\_\_%

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