

Semi-Annual Patient Activity Report

Ohio J-1 Visa Waiver Program



6-month Reporting Period: Year - _____

Select One: _____ January – June
 _____ July - December

Part I – Physician Contact Information

Physician Name				Specialty	
Practice Site Name					
Practice Address					
City		Zip		County	
Phone Number		Fax			
Email					

Part II – Practice Site Patient Payer Mix

Payer	# Unduplicated Patients	# Visits
Medicaid	*	*
Medicare	*	*
Sliding Fee Scale	*	*
Full Fee Self-pay	*	*
No Charge or No Payment by Client	*	*
Private Insurance	*	*
Other (explain)	*	*
Total	A. *	B. *

Part III – Physician's Patient Payer Mix

Payer	# Unduplicated Patients	# Visits
Medicaid	*	*
Medicare	*	*
Sliding Fee Scale	*	*
Full Fee Self-pay	*	*
No Charge or No Payment by Client	*	*
Private Insurance	*	*
Other (explain)	*	*
Total	A. *	B. *

*Numbers in column A cannot be greater than column B.

____ I certify this data is accurate and can be substantiated by a record review.

 Print Name

 Title

 Phone

 Signature

 Date

Part IV - Verification of Leave

The above-named physician has been away from work, including vacation, professional development, sick days, and holidays, for the following number of days during this reporting period: _____ days. I confirm that this physician works: _____ full-time (at least 40 hours per week) in the clinical setting at the above-named site.

 Signature of Site Administrator

 Date

 Phone

The Patient Activity Reporting form is **due to ODH each January 15th and July 15th** showing payer mix data for the prior six month period, i.e. July 1 – December 31 and January 1 – June 30. Return the form to:

Ohio J-1 Visa Waiver Program
 Bureau of Community Health Services & Patient-Centered Primary Care
 Ohio Department of Health
 246 N. High Street – 7th Floor
 Columbus, Ohio 43215