

**Ohio Department of Health
State 30 J-1 Visa Waiver Program
Semi-Annual Patient Activity Report**

6-month Reporting Period: Year - _____ Select One: ____ January – June ____ July - December

If more than one site, please provide a Semi-Annual Patient Activity Report for each site.

Part I – Physician Contact Information

Physician Name				Specialty	
Practice Site Name					
Practice Address					
City		Zip		County	
Phone Number		E-mail			

Part II – Practice Site 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. style="text-align: center;">*	B. style="text-align: center;">*

Part III – Physician’s 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. style="text-align: center;">*	B. style="text-align: center;">*

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

Part IV - Verification of Leave and Certification of Information

The above-named physician provided direct patient care at the listed site for a minimum of _____ hours per week. The physician has been away from work for _____ days, including vacation, holidays, professional education, illness or any other reason. The data on this report is accurate and can be confirmed by a record review.

Name of Site Administrator (Print) Phone E-mail

Signature of Site Administrator Date

Signature of Physician Date

The Patient Activity Reporting form is **due each January 15th and July 15th** showing payer mix data for the prior six month period, i.e.: data for January – June is due July 15th and data for July – December is due January 15th. Please e-mail the completed form to HealthPolicy@odh.ohio.gov and mail a hard copy to: Ohio J-1 Visa Waiver Program, Ohio Department of Health, 246 N. High Street – 7th Floor, Columbus, Ohio 43215