



U.S. DEPARTMENT OF STATE

EMPLOYER ATTESTATION

I, *(please print)* _____ hereby declare, under penalty of the provisions of 18 U.S.C. 1001, that _____
(medical facility/employer)

is located in a primary care or mental health care Health Professional Shortage Area, **

ID# _____, Zip Code _____ and provides medical care to Medicare, Medicaid, and HealthWave patients and offers discounted fees to medically indigent, uninsured patients.

Signature

Date

Subscribed and sworn to before me
this _____ day of _____, 20 ____.

Notary Public

** Current HPSA Identification Number may be found at: <http://bphc.hrsa.gov/databases/newhpsa/newhpsa.cfm>
If the application is for an MUA or MUP it must have a designation date within the past 4 years