# Delta Doctors Program

## Physician Compliance Closing Survey

**Note: Responses to the questions on this survey are strictly confidential. Only designated staff with the Delta Regional Authority will view the responses to the following questions.**

Date: _____

Name: (print or type) _____

Years Served: _____ Employment Start Date:_____

Address: Home:_____ Office:_____
Street Street

_____ _____
City/State/Zip City/State/Zip

_____ _____
Home Phone Work Phone

Physician's E-mail Address: _____

Name of Employer: _____

Address: _____
Street/Location City/State/Zip County

Type of Medical Practice: _____
(Example: General Practice, Family Medicine, Pediatrics, etc.)

I hereby certify that I, the undersigned, provided direct patient care for the above listed employer for 40 hours per week, or 160 hours per month, at a worksite(s) located within a HPSA or MUA. I further attest that the information above is truthful and accurate.

I hereby acknowledge that all information and statements contained herein are true and do not misrepresent facts, per requirements of 18 USC 1001 (Title 18, U.S. Code, Part 1, Chapter 47, Section 1001). I further acknowledge that I have not evaded or suppressed any information contained in this document or in any of the supporting materials.