

**KY J-1 Visa Waiver Program
Six – Month Reporting Form**

Return to: Gary Williams, KY J-1 Visa Waiver Program Administrator
Health Care Access Branch, Dept. for Public Health
275 E. Main St. – HS2WB
Frankfort, KY 40621

(This section to be completed by the Physician on the J-1 Visa Waiver)

Six Months Work Period: _____

Name of Physician _____ State 30 _____ or ARC _____

Sponsor's Name _____

Original Date of Employment _____

Primary Practice Site:

Name of Site: _____

Location Address: _____

City/State/Zip/ County _____

How many hrs a week is the physician engaged in patient care at this location? _____

Additional Practice site:

Give name and location address: _____

Amount of hrs engaged at this location. _____

Do you work at any additional site? If yes, please note in the margin. _____

What percent of your practice serves Medicaid Patients? _____

What percent of your patients are billed on sliding fee scale? _____

How much time were you absent from this position due to illness/vacation/etc. _____

This section to be completed by Sponsor.

Sponsor's Name _____

Name of Practice _____

Sponsor's Mailing Address _____

City/State/Zip _____

Phone Number _____

I certify that the information provided on this form is complete and accurate to the best of my knowledge. I understand that if the physician in my employ on a J-1 Visa Waiver changes employment status or location , I will contact the KY J-1 Visa Waiver Program in the KY Department for Public Health at the address listed above.

Signature: _____ . Date _____