Kentucky Public Health
Prevent. Promote. Protect.

Kentucky J-1 Visa Waiver Program Six (6) Month Reporting Form

Each physician approved under the Kentucky Conrad 30 Visa Waiver Program or the Appalachian Regional Commission's (ARC) Visa Waiver Program must complete this report when the physician first starts work and each 6 months thereafter, until the physician completes their 3-year service obligation.

SECTION 1: TO BE COMPLETED BY THE J-1 VISA WAIVER PHYSICIAN

Please print legibly or type all entries except signatures

Six (6) Months Work Period_____

Name of Physician: _____
(First Name, Middle Initial, Last Name)

Please mark one: Conrad 30 ____ or ARC ____

Sponsor's Name: _____

Original Date of Employment: _____

Primary Practice Site

Name of Site: _____

Location Address: _____

City/State/Zip/County: _____

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

What percent of your practice serves Medicaid patients? _____
What percent of your patients are billed on a sliding fee scale? _____
How much time were you absent from this position due to illness/vacation/etc.? _____

Do you work any additional sites? If yes, please attach the requested information for each site.

SECTION 2: 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 Kentucky J-1 Visa Waiver Program at the Kentucky Department for Public Health at the address listed.

Signature of Sponsor: _____Date: _____

Signature of Physician on J-1 Visa Waiver: _____Date: _____

Return to: Kentucky Department for Public Health
Attn: KY J-1 Visa Waiver Program Administrator
275 East Main Street, HS1W-D
Frankfort, Kentucky 40621