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 ____

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.? ______________

If assigned to additional practice sites, please attach the requested information for each site.

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SECTION 2: TO BE COMPLETED BY SPONSOR

Name of Sponsor: ____________________________________________________________

Sponsor Contact 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, HS2W-B
            Frankfort, Kentucky 40621