KENTUCKY STATE 30 J-1 VISA WAIVER PROGRAM
SPONSOR INFORMATION SHEET

This information sheet must be signed and dated by the sponsor and returned with all requested documentation by October 31 to:

KENTUCKY DEPARTMENT FOR PUBLIC HEALTH
DIVISION OF PREVENTION AND QUALITY IMPROVEMENT
HEALTH CARE ACCESS BRANCH
ATTN: KY J-1 VISA WAIVER PROGRAM ADMINISTRATOR
275 EAST MAIN STREET, HS2W-B
FRANKFORT, KENTUCKY 40621

J-1 PHYSICIAN ___________________________ DOS CASE NUMBER______________

Name of Sponsoring Organization:_________________________________________

Address ________________________________________________________________

City ___________________________ County ___________________________ Zip Code ________

Phone Number ___________________________ Fax Number _______________________

Owner/ CEO /Manager Name ________________________________________________

Services Provided __________________________________________________________________

Call Schedule: Yes  No

HPSA or MUA designation and number __________________________________________
Information regarding the Service Site (if different from the Sponsoring Organization)

Name __________________________________________________________

Street Address _________________________________________________

City __________________________ Zip Code _______ Phone __________

Mailing Address _______________________________________________

City __________________________ Zip Code _______ Fax Number __________

Type of Organization: Private, For Profit ____ Private, Non Profit ____ Public ____

Substantiation of services to the underserved population from previous three years:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of total patients visits</th>
<th>% of individuals not charged</th>
<th>% Medicaid visits</th>
<th>% Medicare visits</th>
<th>% Sliding Fee Scale visits</th>
<th>% Private Pay</th>
</tr>
</thead>
</table>

Name of other J-1 Physicians at the practice site
__________________________________________________________________________

Name of National Health Service Corps Physicians at practice site.
__________________________________________________________________________

What is the location and average distance to the next nearest source of care comparable to the specialty of the J-1 Physician that is available to the clients of this practice site using available public transportation?
__________________________________________________________________________

Rev. 3/21
Proposed Schedule of J-1 Physician. For location, list name of facility. If physician will be working in multiple counties, list name of county under location as well.

<table>
<thead>
<tr>
<th>WEEKDAY</th>
<th>WORK TIME (Example: 7:30AM to 7:30PM)</th>
<th>LOCATION</th>
<th>TOTAL HOURS WORKED</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONDAY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TUESDAY</td>
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</tr>
<tr>
<td>WEDNESDAY</td>
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<tr>
<td>THURSDAY</td>
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<tr>
<td>FRIDAY</td>
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<tr>
<td>SATURDAY</td>
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<tr>
<td>SUNDAY</td>
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</tr>
</tbody>
</table>

________________________________________

Sponsor Representative Signature

________________________________________

Title

________________________________________

Date