Kentucky
J-1 Visa Waiver Program
Six (6) 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 (6) 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 hours a week is the physician engaged in patient care at this location? _____
List any additional practice sites:
Name of Site: _____
Location Address: _____
City/State/Zip/ County: _____

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

Do you work at any additional sites? If yes, please note in the margin or attach requested information.

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

Signature of Sponsor: _____ Date: _____

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