Indiana Department of Health

Mike Braun
Governor

Lindsay M. Weaver, MD, FACEP
State Health Commissioner

Indiana Conrad 30 J-1 Visa Waiver Program

Application Cover Sheet

Personal Information

Name of Applicant: _____ ☐ MD or ☐DO
First ***Middle*** ***Last*** ***Check one ☑***

Country of Origin: _____ DOB: _____

Area of Expertise: _____ Hospitalist: (*check one*) ☐ Yes or ☐ No

Primary care provider or psychiatrist: *(check one)* ☐ Yes or ☐ No

If yes, sign to attest that the applicant does not qualify for a HHS Clinical Care Waiver.

_____
Signature ***Date***

Providing direct patient care* at least 32 hours per week? (*check one*) ☐ Yes or ☐ No
**Direct patient care: Hands on, face-to-face contact with patients for the purpose of prevention, diagnosis, treatment, and/or monitoring.*

If yes, sign to attest that the applicant provides direct patient care (as defined above) at least 32 hours a week. IDOH reserves the right to request additional verification.

_____
Signature ***Date***

Address of Applicant: _____
Street Address

_____
City ***State*** ***ZIP Code***

Phone Number: _____ Fax Number: _____

Email: _____

To promote, protect, and improve the health and safety of all Hoosiers.

Case Review Number: _____

IN Medical License Number: _____

National Provider Identifier (NPI) Number: _____

Application Pending: (*check one*) ☐Yes or ☐No

Attorney Information

Attorney/Firm Representing the Applicant: _____

Address: _____
Street ***City*** ***State*** ***ZIP Code***

Phone: _____ Fax: _____

Email: _____

Facility Information

Employer: _____

Employer's Contact Person: _____
Name ***Title***

Address (include county): _____
Street

_____
City ***County*** ***State*** ***ZIP Code***

Phone: _____ Fax: _____

Email: _____

Practice Site #_____

Practice Name: _____

_____

Street ***City*** ***County*** ***ZIP Code***

Phone: _____ Fax: _____ Email: _____

HPSA ID # _____ MUA/MUP ID# _____

Census Tract # _____ FIPS County Code _____

Type of Facility: (*Check box in front of facility type*)

☑	**Type of Facility**	☑	**Type of Facility**
☐	Hospital	☐	Safety Net Provider
☐	Federally Qualified Health Center/Look Alike	☐	State funded Community Health Center
☐	Rural Health Clinic (*not for profit only*)	☐	Indiana Department of Health Funded Facility
☐	Other (*specify)*		

If there are multiple sites, please provide the number of hours per week or percentage of time the physician will practice at this site _____ (*percentages for all sites should equal 100% of one FTE*).

Please go to the next page and input all information for each site in the space provided.

Practice Site #_____

Practice Name: _____

_____

Street ***City*** ***County*** ***ZIP Code***

Phone: _____ Fax: _____ Email: _____

HPSA ID # _____ MUA/MUP ID# _____

Census Tract # _____ FIPS County Code _____

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☐	Federally Qualified Health Center/Look Alike	☐	State funded Community Health Center
☐	Rural Health Clinic (*not for profit only*)	☐	Indiana Department of Health Funded Facility
☐	Other (*specify)*		

Number of hours per week or percentage of time the physician will practice at this site: _____

Practice Site #_____

Practice Name: _____

_____

Street ***City*** ***County*** ***ZIP Code***

Phone: _____ Fax: _____ Email: _____

HPSA ID # _____ MUA/MUP ID# _____

Census Tract # _____ FIPS County Code _____

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☐	Other (*specify)*		

Number of hours per week or percentage of time the physician will practice at this site: ____

Practice Site #_____

Practice Name: _____

_____

Street ***City*** ***County*** ***ZIP Code***

Phone: _____ Fax: _____ Email: _____

HPSA ID # _____ MUA/MUP ID# _____

Census Tract # _____ FIPS County Code _____

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