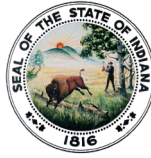




**Indiana
Department
of
Health**



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)

<input checked="" type="checkbox"/>	Type of Facility	<input checked="" type="checkbox"/>	Type of Facility
<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Safety Net Provider
<input type="checkbox"/>	Federally Qualified Health Center/Look Alike	<input type="checkbox"/>	State funded Community Health Center
<input type="checkbox"/>	Rural Health Clinic (<i>not for profit only</i>)	<input type="checkbox"/>	Indiana Department of Health Funded Facility
<input type="checkbox"/>	Other (<i>specify</i>)		

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 _____

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

<input checked="" type="checkbox"/>	Type of Facility	<input checked="" type="checkbox"/>	Type of Facility
<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Safety Net Provider
<input type="checkbox"/>	Federally Qualified Health Center/Look Alike	<input type="checkbox"/>	State funded Community Health Center
<input type="checkbox"/>	Rural Health Clinic (<i>not for profit only</i>)	<input type="checkbox"/>	Indiana Department of Health Funded Facility
<input type="checkbox"/>	Other (<i>specify</i>)		

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 _____



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

<input checked="" type="checkbox"/>	Type of Facility	<input checked="" type="checkbox"/>	Type of Facility
<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Safety Net Provider
<input type="checkbox"/>	Federally Qualified Health Center/Look Alike	<input type="checkbox"/>	State funded Community Health Center
<input type="checkbox"/>	Rural Health Clinic (<i>not for profit only</i>)	<input type="checkbox"/>	Indiana Department of Health Funded Facility
<input type="checkbox"/>	Other (<i>specify</i>)		

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 _____

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

<input checked="" type="checkbox"/>	Type of Facility	<input checked="" type="checkbox"/>	Type of Facility
<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Safety Net Provider
<input type="checkbox"/>	Federally Qualified Health Center/Look Alike	<input type="checkbox"/>	State funded Community Health Center
<input type="checkbox"/>	Rural Health Clinic (<i>not for profit only</i>)	<input type="checkbox"/>	Indiana Department of Health Funded Facility
<input type="checkbox"/>	Other (<i>specify</i>)		

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