KANSAS PHYSICIAN/EMPLOYER REPORTING FORM

Please submit within the first thirty days of commencement of practice and yearly thereafter.

Physician:

Name: (please print) _____

Medical Practice Address: _____

_____

County_____ Phone #_____

I hereby declare and certify that I, the undersigned, have practiced _____
Specialty

medicine at the above-stated address a minimum of 40 hours per week since _____
Date: mo/day/year

_____ _____
Physician Signature Date

This form indicates my participation is in which year? ◯ 1st Year ◯ 2nd Year ◯ 3rd Year

Answer this question only at the end of the third year of the 3-year contract:	I Will ◯ I Will Not ◯ (*check one*) remain in this location to practice medicine.

Employer:

I hereby declare and certify that Dr._____is employed by

_____ at the above-stated address and provides at least

40 hours of_____medicine per week.
Specialty

_____ _____
Signature Date

Subscribed and sworn to before me

this_____day of_____, 20____.

Notary Public

KDHE Division of Health
Bureau of Community Health Systems
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Voice 785-296-1200 Fax 785-296-1231 http://www.kdheks.gov/olrh/index.html