Kansas Department of Health and Environment
J-1 Visa Waiver Program

Internal Office Use Only

DOS #: ______________

KDHE #:_____________

Form must be fully complete and submitted with the application package.

General Inquiry Form

First Name: ______________________________ Last Name:_____________________________________

Female: __________ Male:________ ECFMG #: __________________ DOS #: _________________

NPI #: _____________ Physician Email: _____________________________________Date of Birth:_____________

Employer: ____

CEO: _________________________________ Phone #: ______________Email: ________________________

Contact Person: ________________________ Phone #: ______________Email: ________________________

Employer Business Address: ____

City: _________________________________ State: _______________ Zip Code: _________________________

Street Address of Facility/Practice Site: ____

City: __________________ State: __________ Zip Code: ___________ HPSA #: ______________________

If the physician will be working in more than one facility/practice sites, provide a list of all physical locations as an attachment to this form.

Select the Best Appropriate Category for the Physician, based descriptions provided below. Select only one option.

☐ Physician who is board certified in Family Practice, General Internal Medicine, General Pediatrics, Obstetrics/Gynecology, Emergency Medicine or Psychiatry; and will be working in an outpatient, ambulatory care setting.

☐ Physician who is board certified in a primary care specialty (listed above) and will be serving in the capacity as a Hospitalist; OR Physician who is board certified in a non-primary care specialty directly related to the management of time critical diagnoses (STEMi, Stroke, and Trauma).

☐ Physician who is board certified in non-primary care specialty that directly supports the coordination of care for patients with chronic disease (e.g., diabetes, heart disease).

☐ Physician who is board certified in all other specialties.

List Physician's Specialty: ____________________________.

(Optional) Additional Information as it relates to the physician specialty. (Limit 100 words)

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Attorney Name: ___________________________________ Law Firm: _______________________________________

Business Address: ____

City: ____________________________________ State: __________________ Zip Code: ___________________

Point of Contact: ____

Phone #: ______________________________ Email: ____