Indiana J-1 Visa Waiver Program
The Indiana State Department of Health

Application Cover Sheet

Personal Information

Name of Applicant: _____ MD DO
First *Middle* *Last* *Circle One*

Country of Origin _____ DOB: _____

Area of Expertise _____ Hospitalist: (*Circle one*) Yes No

Address of Applicant: _____
Street Address

_____
City *State* *Zip Code*

Phone Number: _____ Fax Number: _____

Email: _____ Pager Number (optional)_____

Case Review Number:_____

IN Medical License Number_____ Application Pending _____
Check if applicable

Attorney Information

Attorney/Firm Representing the Applicant: _____

Address: _____
Street *City* *State* *Zip*

Phone: _____ Fax: _____

Email: _____

Facility Information

Employer: _____

Employer's Contact Person _____
Name *Title*

Address: (Include the County): _____
Street

_____
City *County* *State* *Zip*

Phone: _____ Fax: _____

Email: _____

Practice Site# 1 Address *(If different from employer's, provide Practice Name, Address, Phone, Fax, and Email.)*

Practice Name: _____

_____
Street *City* *County* *State* *Zip*

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 State Dept. of Health Funded Facility
	Other *(Specify)*		

If there are multiple sites,
please provide the number of hours/week the physician will practice at this site: _____ or

percent of time at this site _____% *(percentages for all sites should equal 100% of 1 FTE.)*

If there are multiple sites, go to the next page and provide all information for each site in the space provided.

If there are more sites than space provided, duplicate this page before filling it out.

Practice Site#_____ **Address** *(If different from employer's, provide Practice Name, Address, Phone, Fax, and Email.)*

Practice Name: _____

_____

Street *City* *County* *State* *Zip*

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**
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	Other *(Specify)*		

Number of hours/week the physician will practice at this site: _____ or percent of time _____%

Practice Site#_____ **Address** *(If different from employer's, provide Practice Name, Address, Phone, Fax, and Email.)*

Practice Name: _____

_____

Street *City* *County* *State* *Zip*

Phone: _____ Fax: _____ Email: _____

HPSA ID #_____ MUA/MUP ID# _____

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Number of hours/week the physician will practice at this site: _____ or percent of time _____%