



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

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.
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Employer:

I hereby declare and certify that Dr. _____ is employed by
_____ at the above-stated address and provides at
least 40 hours of _____
Specialty medicine per week.

Signature

Date

Subscribed and sworn to before me
this _____ day of _____, 20____.
Notary Public