North Carolina State Conrad 30 Program Application Cover Sheet

This cover sheet must be completed by all practice sites proposing to employ physicians under the North Carolina State Conrad 30 J-1 Visa waiver program. Please complete and mail, along with all other requested materials, to: North Carolina Office of Rural Health, North Carolina State Conrad 30 Program, 2009 Mail Service Center, Raleigh, NC 27699-2009 (Phone: 919-527-6440)

Please print clearly or fill out electronically.

Physician Last Name: ______________________ M D D O

Physician First Name: ______________________ MI:______ Male:____ Female:____

City: ______________________ State: __________ Zip: ______________

Phone #: ______________________ Email (post training): ______________________

Specialty: ______________________ Country of Citizenship:______________________

Birth Date MM/DD/YYYY: ______________________ Dept. of State (DOS) Case #:______________________

NPI: ______________ NC Physician Full License # (if applicable): ______________________

Anticipated Start Date: MM/DD/YYYY: ______________________

Employer Name: ______________________

Employer Address: ______________________

City: ______________________ State: __________ Zip:______________

Employer Contact Name: ______________________ Phone:______________________

Email Contact: ______________________

Practice Site Name:______________________

Site Contact Name (*If different from Employer)*:______________________ Phone: ______________________

Email Contact: ______________________

Practice Site 1 Address: ______________________

City:______________________ State:__________ Zip:____________ County: ______________________

Health Professional Shortage Area (HPSA) ID # (if applicable): ______________________

Medicaid Billing #: ______________________ Medicare Billing #: ______________________

Please complete new form for any additional sites.

Attorney Last Name: ______________________ First Name: ______________________

Firm Name:______________________

Address: ______________________

City: ______________________ State: ______________ Zip: ______________

Direct Phone #: ______________________ AttorneyEmail:______________________