



**KENTUCKY PHYSICIANS CARE PROGRAM
PARTICIPATING PHYSICIAN AGREEMENT**

Yes, I will participate in the Kentucky Physicians Care Program, by providing services without charge for the first office visit to eligible patients.

CHOOSE ONE: _____ I am a Physician
 _____ I am a Physician's Assistant of _____, M.D.

CHOOSE ONE: _____ I agree to see KPC patients as necessary each month.
 _____ I agree to see up to (#) _____ KPC patients per month.

NAME: _____

STATE LICENSE # _____ EXP. DATE _____

SPECIALTY _____

OFFICE ADDRESS _____

CITY _____ ZIP _____

COUNTY _____ E-MAIL ADDRESS _____

OFFICE PHONE (_____) _____ FAX (_____) _____

SIGNATURE _____ DATE _____

Please complete and mail to:

**Health Kentucky, Inc.
83 C. Michael Davenport Blvd.
Frankfort, Kentucky 40601
(502) 227-3158**