



I support Project Access – the Medical Society of Sedgwick County’s coordinated effort to help low-income, uninsured people access donated medical care.

- I pledge to accept 10 Project Access patients a year (20 if a specialist) to my usual medical practice *or*
- I pledge to accept _____ Project Access patients a year.

Participating in Project Access requires physicians have an active Kansas medical license. I hold a current Kansas medical license. Yes No

NAME _____
please print

signature

GROUP NAME _____

- Primary Care Specialist

specialty

Please sign this card and the Kansas Charitable Health Care Provider Form and return to:

Project Access
1102 S. Hillside
Wichita, KS 67211

thank you!