



# Kansas Regional Extension Center Expression of Interest

Please complete all sections and fax to **785-271-4181** or **785-271-4182** as soon as possible.

**QUESTIONS:**  
 Donna Garwood, RN, BSN, CPHQ  
 Phone: 785-271-4118  
 Email: dgarwood@kfmc.org

Practice Name: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Phone: \_\_\_\_\_

# MDs/DOs: \_\_\_\_\_ # PAs/ARNPs: \_\_\_\_\_ # Practice Sites: \_\_\_\_\_

**YES**, on behalf of our practice, I submit this expression of interest to participate in education, outreach and direct technical assistance provided by KFMC to understand, select and implement technology needed to attain and demonstrate meaningful use requirements.. We understand these activities will assist providers in meeting the requirements of future incentive programs which may provide a payment of up to \$44,000 from Medicare or \$65,000 from Medicaid for each eligible professional.

\_\_\_\_\_/\_\_\_\_\_/2009  
*Physician / Administrator Signature*                      *Physician / Administrator Printed*                      *Date*

Please provide the information below for all health care professionals with prescriptive privileges at your location:

Name	NPI Number	Credentials	Specialty

Attach separate page if needed.

Has your practice implemented a certified Electronic Health Record (EHR)?     Yes     No  
 Have you purchased a certified EHR, but have yet to implement?             Yes     No

Practice Contact Name: \_\_\_\_\_

E-mail address: \_\_\_\_\_