J-1 VISA WAIVER PHYSICIAN VERIFICATION OF EMPLOYMENT FORM

SECTION I

PLEASE CHECK WAIVER PROGRAM: Conrad State 30 ☐ ARC ☐

PHYSICIAN NAME:_____
Please Print

EMPLOYMENT START DATE AT SPONSORING MEDICAL FACILITY: _____

INS J-1 Visa Waiver Approval Date: _____ H-1B Visa Approval Date: _____

PHYSICIAN'S HOME ADDRESS:

_____
Street City State Zip Code:

Email: _____

Home Phone: _____ CELL Phone: _____

SECTION II
PRACTICE SITE INFORMATION

Name Site 1:	Name Site 2:
Street Address:	Street Address:
City, State, ZIP	City, State, ZIP
Site Phone #:	Site Phone #:

SECTION III

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE OR SPECIALITY CARE (IF APPROVED AS SPECIALIST) AT THE ABOVE STATED SITE(S) A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Physician's Signature **Date**

SECTION IV
THIS SECTION TO BE COMPLETED AND SIGNED BY SPONSORING MEDICAL FACILITY:

I HEREBY CERTIFY THAT DOCTOR_____

(Please Check Below As Applicable)

(___) IS WORKING AT SITE(S) LISTED IN SECTION II AND IS IN YEAR _____ OF SERVICE OBLIGATION

(___) HAS COMPLETED SERVICE OBLIGATION AND *STILL* AT SITE(S) LISTED IN SECTION II

(___) HAS COMPLETED SERVICE OBLIGATION AND NO LONGER AT SITE(S) LISTED IN SECTION II

(___) DID NOT COMPLETE SERVICE OBLIGATION

(___) TRANSFERRED

(___) WILL START ON _____ AT SITE(S) LISTED IN SECTION II

_____
Printed Name of Sponsoring Medical Facility Representative

_____ _____
Signature of Sponsoring Medical Facility Representative **Date**

(THIS FORM MUST BE NOTARIZED)

RETURN THIS FORM BY MAIL TO:
Mississippi State Department of Health
ATTN: Director, Office of Rural Health & Primary Care
570 East Woodrow Wilson - P. O. Box 1700
Jackson, Mississippi 39215-1700

J-1 VISA WAIVER PHYSICIAN VERIFICATION OF EMPLOYMENT FORM
Form #827E
(Form located on the Primary Care page of the MSDH website)

PURPOSE

The purpose of this form is to verify the employment status of J-1 VISA Waiver Physicians recommended for approval by the Mississippi State Department of Health. The physicians are required to work at least three years (or more if stated in contract agreement) at the sponsoring medical facility approved practice site(s).

INSTRUCTIONS

J-1 VISA Waiver Physicians recommended for approval by the Mississippi State Department of Health and a representative of the medical facility sponsoring the J-1 VISA Waiver Physician should complete and submit the form to the Primary Care Office (PCO) once the physician begins employment with the sponsoring medical facility and annually thereafter. The PCO will mail the form to the active J-1 Physicians in the PCO database. **This Form Must Be Notarized.**

The following should be provided on the form:

Section I
Check type of J-1 VISA Waiver Program.

The J-1 VISA Waiver Physician should provide contact information in Section I. Information includes the physician's name, complete home address, home telephone number, cell phone number, and email address.

Also in Section I, the J-1 VISA Waiver Physician should provide approval dates of the J-1 VISA Waiver and H-1B.

Section II
The J-1 VISA Waiver Physician should provide the following for the sponsoring medical facility practice site(s): facility name, complete address, and telephone number.

Section III
J-1 VISA Waiver Physician must certify working 40 hours per week providing health services at the medical facility practice site(s) listed in Section II.

Section IV
A representative of the sponsoring medical facility must certify that the J-1 VISA Waiver Physician is or is not working at the practice site(s) listed in Section II.

Revised 01/05/2012