J-1 Visa Waiver Program

Physician Employment Verification Form

- **This form is not to be submitted with the waiver application, but is to be completed and mailed to the DRA within the physician's first week of practice.**
- **Include copies of the physician's state medical license with this form if they were not included / available at the time the J-1 Waiver Application was submitted. Also include copies of I-94 renewals and approval notices with this document.**
- **If the physician will be providing services for the employer at different sites than the office site listed below, please provide those addresses on a separate page and attach to this form.**

PHYSICIAN:

Name: (print or type)_____ Employment Start Date:_____

I-612 Approval Date: _____ H-1(b) Approval Date: _____

Address: Home: _____ Office: _____
Street Street

_____ _____
City/State/Zip City/State/Zip

_____ _____
Home Phone Work Phone

Physician's E-mail Address: _____

I hereby certify that I, the undersigned, do provide primary health care services at the above stated address for a minimum of 40 hours per week or 160 hours per month.

Physician's Signature_____ Date:_____

EMPLOYER:

Name of Employer: _____

Address: _____ City/State/Zip: _____

County: _____

Type of Medical Practice: _____
(Example: General Practice, Family Medicine, Pediatrics, etc.)

Point of Contact Name: _____

Phone Number: _____ Email: _____

I do hereby certify that Doctor _____ is employed by

_____ and provides 40

hours of direct patient care per week, or 160 hours per month, at the above stated address.

_____
Employer's Signature

_____
Employer's Printed Name

_____
Date