J-1 Visa Waiver Program

Physician Compliance Survey Part B (Physician)

Note: Responses to the questions listed on page two and three are strictly confidential. Only designated staff with the Delta Regional Authority will view the responses to those questions.

Year: _____ Survey Number: _____

Survey Period: _____ Survey Date: _____

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: _____

Name of Worksite (Please provide data for each worksite): _____

Worksite Address: _____
Street/Location City/State/Zip County

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

Please indicate the number of patients that **you** have seen in the past six months.

Total No. of Patients: _____

No. of Private Pay Patients: _____ % of Total Patients: 0.00%

No. of Medicare Patients: _____ %of Total Patients: 0.00%

No. of Medicaid Patients: _____ % of Total Patients: 0.00%

No. of Indigent Patients: _____ % of Total Patients: 0.00%

No. of Other Patients: _____ % of Total Patients: 0.00%

Please indicate the number of patients that the **facility** has treated in the past six months.

Total No. of Patients: _____

No. of Private Pay Patients: _____ % of Total Patients: 0.00%

No. of Medicare Patients: _____ %of Total Patients: 0.00%

No. of Medicaid Patients: _____ % of Total Patients: 0.00%

No. of Indigent Patients: _____ % of Total Patients: 0.00%

No. of Other Patients: _____ % of Total Patients: 0.00%

I hereby certify that I, the undersigned, do provide direct patient care at the above stated worksite(s) for 40 hours per week, or 160 hours per month. I further attest that the information above is truthful and accurate.

Physician's Signature_____ Date:_____

Please answer the following questions in accordance with the indicated scale:

4=Excellent, 3=Good, 2=Average, 1=Poor

1. How would you rate your overall experience with the medical facility described above thus far? _____
2. How would you rate the way the administrator(s) of the medical facility has followed the terms set forth in the employment contract? _____
3. How would you rate the way that you have been treated by the administrator(s) of the medical facility described above? _____
4. How would you rate the way you have been accepted by patients at the medical facility described above? _____
5. How would you rate the way you have been welcomed by the local community? _____

Please use the space provided to make any positive statement or comment on any problem or concern that you have in regard to the medical facility listed above.

Please Return Form To:

Delta Regional Authority
Attention: Delta Doctors Program
236 Sharkey Avenue, Suite 400
Clarksdale, MS 38614