J-1 Visa Waiver Program

Completion Request Form

Physician's Name:____

Current Home Address:

Street:____

City: ____________________ State:___________ Zip Code:_________

Home Phone: ____

Email Address: ____

Employer's Name: ____

Street:____

City: ____________________ State:___________ Zip Code:__________

Phone: ____

Email Address: ____

Point of Contact: ____

Worksite(s): Please list additional worksites on Page 3:

Name: ____

Street: ____

City: ____________________ State:___________ Zip Code:__________

County: ________________________________

HPSA: ____ MUA: ______

Dates of Employment:________________ to ________________

Date of Completion: _____________________________________

I HEREBY CERTIFY THAT I, ____, PROVIDED DIRECT PATIENT CARE AT THE WORKSITE(S) LISTED FOR FORTY (40) HOURS PER WEEK, OR ONE HUNDRED SIXTY (160) HOURS PER MONTH, FOR THREE (3) YEARS.

Physician's Signature: __________________________________

Date: ____

I HEREBY CERTFIY THAT DOCTOR ___________________________________ PROVIDED DIRECT PARTIENT CARE AT THE WORKSITE(S) LISTED FOR FORTY (40) HOURS PER WEEK, OR ONE HUNDRED SIXTY (160) HOURS PER MONTH, FOR THREE (3) YEARS.

Employer's Signature: __________________________________

Date: ____

ADDITIONAL WORKSITES

Name: ____

Street: ____

City: ___________________ State:___________ Zip Code:__________

County: _______________________________

HPSA: ____ MUA: ______

Dates of Employment:________________ to ________________

Date of Completion: ____________________________________

Name: ____

Street: ____

City: ___________________ State:___________ Zip Code:__________

County: _______________________________

HPSA: ____ MUA: ______

Dates of Employment:________________ to ________________

Date of Completion: ____________________________________

Name: ____

Street: ____

City: ___________________ State:___________ Zip Code:__________

County: _______________________________

HPSA: ____ MUA: ______

Dates of Employment:________________ to ________________

Date of Completion: ____________________________________