J-1 Visa Waiver Program

Physician Compliance Survey Part A (Employer)

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 of Physician: _____

I-612 Approval Date: _____

H-1(b) Approval Date: _____

Employment Start Date: _____

Name of Employer: _____

Point of Contact: _____

Phone Number: _____

E-mail Address: _____

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

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

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

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% _____

Please indicate the number of patients that the **physician** has 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% _____

I do hereby certify that Doctor _____ is

employed by _____

and provides 40 hours of direct patient care per week, or 160 hours per month.

_____ _____ _____

Employer's Signature Employer's Name and Title 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 physician described above thus far? _____
2. How would you rate the way the physician has followed the terms set forth in the employment contract? _____
3. How would you rate the physician's ability to communicate effectively with other physicians, nurses, patients, etc.? _____
4. How would you rate the way the physician has been accepted by patients at your medical facility? _____
5. How would you rate the way the physician has been welcomed by the local community? _____

Please use the space provided below to make any positive statement or comment on any problem or concern that you have in regard to the physician described above.

Please Return Form To:

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