Appalachian Regional Commission

J-1 Placement Verification Form

Physician Name:_____

USCIS J-1 Visa Waiver Approval Date: _____ H-1(b) Visa Approval Date: _____

ARC Commitment Employment Start Date: _____ (within 90 days of USCIS approval of ARC J-1 Visa Waiver request)

Home Address:
Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Type of Medical Practice: _____

Location of Medical Specialty:
Street: _____

City: _____State: _____

County: _____

HPSA: _____

Phone: _____ Email: _____

Additional locations (if applicable):
_____
_____
_____

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE SERVICES AT THE ABOVE STATED LOCATION(S) A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Physician Signature (Notary) Date

I HEREBY CERTIFY THAT DOCTOR _____ PROVIDES A MINIMUM OF 40 HOURS PER WEEK OF PRIMARY HEALTH CARE IN THE ABOVE LISTED ARC HPSA LOCATION(S).

_____ _____ _____ _____
Sponsor Signature (Notary) Date Phone Email

_____
Printed Name

RETURN THIS FORM TO:
Deann Reed Fairfax, J-1 Program Manager
dfairfax@arc.gov

SEND COPY TO ARC J-1 CONTACT IN REQUESTED STATE
List available at www.arc.gov