



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 Practice:

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

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

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