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                      Date
(Notary)

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                     Phone                          Email
(Notary)

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