Appalachian Regional Commission

J-1 Transfer Notification Form

Physician Name: _____

Home Address:
Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Sponsor Name: _____

Present Location of Medical Practice:
Street: _____

City: _____State: _____

County: _____

HPSA: _____

Phone: _____

Date of Transfer: _____

Sponsor Name: _____

New Location of Medical Practice:
Street: _____

City: _____State: _____

County: _____

HPSA: _____

Phone: _____

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE SERVICES AT THE NEW LOCATION A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Physician Signature (Notary) Date

I HEREBY CERTIFY THAT DOCTOR _____ PROVIDES PRIMARY HEALTH CARE SERVICES AT THE NEW ARC HPSA LOCATION A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
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