Bureau for Public Health
Office of Community Health Systems & Health Promotion
Division of Rural Health & Recruitment
State Office of Rural Health
350 Capitol Street, Room 515
Charleston, WV, 25301-3717
(304) 352-6035

J-1 Visa Waiver Program: Placement Verification Form

Within 30 days of the start of employment, the J-1 Physician, the employer/service site(s) are required to submit a Placement Verification Form to WV's SORH. Please complete all fields. If a field is not applicable, write "N/A" (not applicable) in the designated space. *Leaving fields blank may result in delays or rejection of this document.* For further information or to return this form, please contact or email to:

Wendy Castaneda
J-1 Visa Waiver Coordinator for WV State Office of Rural Health
Email: wendy.p.castaneda@wv.gov Phone: (304) 352-6005

Physician Information:

Physician Name: _____ NPI#: _____

Phone: _____ Email Address: _____

Specialty: _____ Sub-specialty (if applicable): _____

USCIS J-1 Visa Waiver Approval Date: _____ H-1B Visa Approval Date: _____

Employment Start Date: _____

Sponsor Information:

Sponsor's Name: _____

Sponsor's Representative: _____

Representative's Title: _____

Telephone:_____ Email:_____

Clinical Site Information:

Practice Address: _____

County: _____ HPSA#: _____ MUA: _____

Practice Address: _____

County: _____ HPSA#: _____ MUA: _____

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County: _____ HPSA#: _____ MUA: _____

Practice Address: _____

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Practice Address: _____

County: _____ HPSA#: _____ MUA: _____

Acknowledgment:

I hereby certify that I, the undersigned, will provide full-time primary health care or specialty services at the above-stated address(es) a minimum of 40 hours per week for 3 years. I agree to notify the West Virginia State Office of Rural Health (WV-SORH) of any changes in my intent to practice at the site(s) identified in the application and/or contract with the WV-SORH. Any deviation from this agreement may result in notification by the WV-SORH to the U.S. Department of State and the U.S. Citizenship and Immigration Service. I also confirm that I possess a current West Virginia medical license and have undergone thorough credentialing.

Physician's Name: _____ Date:_____

Physician's Signature: _____

Sponsor Representative's Name: _____ Date: _____

Sponsor Representative's Signature: _____