Bureau for Public Health
Office of Community Health Systems
WV Division of Rural Health and Recruitment

J-1 Visa Placement Verification Form

Physician Name: ______________________________

USCIS J-1 Visa Waiver Approval Date: ______________________________

H-1 (B) Visa Approval Date: ______________________________

Employment Start Date: ______________________________

NPI #: ______________________________

Home Address: ______________________________

City: ____________ State: ____________ Zip Code: ____________

Home Phone: ______________________________

Practice Address: ______________________________

City: ____________ State: ____________ Zip Code: ____________

Practice Address: ______________________________

City: ____________ State: ____________ Zip Code: ____________

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

______________________________ ____________________
Physician Signature Date

RETURN THIS FORM TO:
Bethlhem Amare, J-1 Visa Coordinator
WV Division of Rural Health and Recruitment
350 Capitol Street, Room 515
Charleston, West Virginia 25301-1757