J-1 Physician Visa Waiver Program New Arrival Verification Form

I, _____, a Physician participating in the Nevada J-1 Visa Waiver Program certify that I have arrived for work at the below referenced site(s) on ___/___/___.

Provider's Name: _____ Email: _____

Telephone #: _____ Start Date: ___/___/___ Anticipated End Date: ___/___/___

Please list your current work assignments given to you by your sponsor (include clinic call, hospital rounding, and emergency room or hospital call):

Address(s) of Work Assignment(s)	**HPSA or MUA/MUP ID#**	**Number of Hours per week**

_____

Signature of Supervising Physician Date

_____

Signature of Site/Facility Executive Director/CEO Date

I hereby certify that I, the undersigned, will provide primary health care or specialty services at the above-stated address(s) a minimum of 40 hours per week for three years. Deviation from such site may result in notification by the Nevada Division of Public and Behavioral Health to appropriate federal agencies.

_____

Physician's Signature Date

Return Completed Form By Email or Mail To: Primary Care Office
Nevada Division of Public and Behavioral Health
4150 Technology Way, Suite 300
Carson City, Nevada 89706
Office: (775) 684-2232
Or by email (secured as necessary) to jtucker@health.nv.gov