

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, Fax or Mail To:
 Primary Care Office
 Nevada Division of Public and Behavioral Health
 4126 Technology Way, 2nd Floor
 Carson City, Nevada 89706
 Office: (775) 684-2232
 Fax: (775) 684-5999
 Or by email (secured as necessary) to jtucker@health.nv.gov