Nevada Primary Care Office - Conrad State 30 J-1 Visa Waiver Program
Verification of Status

I, _____ , a Physician participating in the Nevada Conrad 30/J-1 Visa Physician certify that I have arrived for work at the below referenced site(s) on (Date):_____ and my anticipated end date (3 years) is _____

Physician's contact information:

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Employer/Sponsor's Business Name: _____

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

Site/Practice Name*	Address(s) of Work Assignment(s)	City	HPSA or MUA/MUP ID#	Hours per Week

If more than two sites, please use the back of this page and indicate the amount of time spent providing primary care at each location.

The undersigned affirms that the information is correct to the best of their knowledge. Additionally, all parties signing (Employer/Sponsor and Physician) confirm and acknowledge that they have read and understood all information contained in the Conrad 30 J-1 Visa Waiver Physician and Employer/Sponsor Rights and Responsibilities Presentation located on the Conrad 30 J-1 Visa Waiver Information, Instructions and Forms website.

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 (3) 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 _____

*Send completed form to **nvpco@health.nv.gov***