J-1 Physician Visa Waiver Program Change of Practice Location

J-1 Physician Name: _____ Email: _____

Cell Phone: (____) _____ E-mail address: _____

Current Practice Address: _____ Telephone #: _____

Proposed Start Date at New Facility: ___/___/___ Proposed Provider Discipline:_____

Original J-1 Waiver Start Date: ___/___/___ Anticipated End Date: ___/___/___

Reason for transfer or change of practice location: _____

_____

_____

Please list the proposed work assignments (include clinic call, hospital rounding, and emergency room or hospital call)

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

_____

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

Documents Required for Change in Practice Location

1. An attestation that each practice site must accept all patients regardless of ability to pay, accept Medicaid, Nevada Check-Up and Medicare on assignment, and use a sliding-fee scale based on federal poverty guidelines to discount services to low-income uninsured persons.
2. A copy of practice sites' sliding fee scale policy and sliding fee scale. The sliding fee scale should be based on family size and income. The policy should identify the minimum fee charged at the site for patients at or below 100% of the Federal Poverty Level.
3. Attach a matrix of the # of Medicaid, Nevada Check-up and charity cases served in the previous 3 months at the facility.
4. Describe and document the employer's recruitment and retention efforts. The employer must demonstrate that a suitable physician with US citizenship cannot be found through recruitment or any other means

for at least two months prior to the submission of the application.

5. Updated employment contract

Return Completed Form and Documents by Email:

to nvpco@health.nv.gov