J-1 Visa Waiver Program

Completion Request Form

Physician's Name:_____

Current Home Address:

Street:_____

City: _____ State:_____ Zip Code:_____

Home Phone: _____

Email Address: _____

Employer's Name: _____

Street:_____

City: _____ State:_____ Zip Code:_____

Phone: _____

Email Address: _____

Point of Contact: _____

Worksite(s): Please list additional worksites on Page 3:

Name: _____

Street: _____

City: _____ State:_____ Zip Code:_____

County: _____

HPSA: _____ MUA: _____

Dates of Employment:_____ to _____

Date of Completion: _____

I HEREBY CERTIFY THAT I, _____, PROVIDED DIRECT PATIENT CARE AT THE WORKSITE(S) LISTED FOR FORTY (40) HOURS PER WEEK, OR ONE HUNDRED SIXTY (160) HOURS PER MONTH, FOR THREE (3) YEARS.

Physician's Signature: _____

Date: _____

I HEREBY CERTFIY THAT DOCTOR _____ PROVIDED DIRECT PARTIENT CARE AT THE WORKSITE(S) LISTED FOR FORTY (40) HOURS PER WEEK, OR ONE HUNDRED SIXTY (160) HOURS PER MONTH, FOR THREE (3) YEARS.

Employer's Signature: _____

Date: _____

ADDITIONAL WORKSITES

Name: _____

Street: _____

City: _____ State:_____ Zip Code:_____

County: _____

HPSA: _____ MUA: _____

Dates of Employment:_____ to _____

Date of Completion: _____

Name: _____

Street: _____

City: _____ State:_____ Zip Code:_____

County: _____

HPSA: _____ MUA: _____

Dates of Employment:_____ to _____

Date of Completion: _____

Name: _____

Street: _____

City: _____ State:_____ Zip Code:_____

County: _____

HPSA: _____ MUA: _____

Dates of Employment:_____ to _____

Date of Completion: _____