J-1 Visa Waiver Program

Physician Compliance Survey (Employer)

Note: Responses to the questions listed on page two and three are strictly confidential. Only designated staff with the Delta Regional Authority will view the responses to those questions.

Year: ________________________ Survey Number: _____________________

Survey Period: _________________ Survey Date: _______________________

Name of Physician: ____

I-612 Approval Date: ____________________________

H-1(b) Approval Date: ___________________________

Employment Start Date: __________________________

Name of Employer: ____

Point of Contact: ____

Phone Number: ____

E-mail Address: ____

Name of Worksite (Please provide data for each worksite): _____________________________________

Type of Medical Practice: ____
(Example: General Practice, Family Medicine, Pediatrics, etc.)

Worksite Address: ____
Street/Location City/State/Zip County

<u>Please indicate the number of patients that the **facility** has treated in the past six months.</u>

Total No. of Patients: ____________________

No. of Private Pay Patients: _______________ % of Total Patients: _______________

No. of Medicare Patients: _________________ % of Total Patients: _______________

No. of Medicaid Patients: _________________ % of Total Patients: _________________

No. of Indigent Patients: __________________ % of Total Patients: _________________

No. of Other Patients: ____________________ % of Total Patients: _________________

Please indicate the number of patients that the **physician** has seen in the past six months.

Total No. of Patients: ____________________

No. of Private Pay Patients: _______________ % of Total Patients: _________________

No. of Medicare Patients: _________________ %of Total Patients: _________________

No. of Medicaid Patients: _________________ % of Total Patients: _________________

No. of Indigent Patients: __________________ % of Total Patients: _________________

No. of Other Patients: ____________________ % of Total Patients: _________________

I do hereby certify that Doctor ____ is

employed by ____

and provides 40 hours of direct patient care per week, or 160 hours per month.

___________________________ ___________________________ ____________________
Employer's Signature Employer's Name and Title Date

Please answer the following questions in accordance with the indicated scale:

4=Excellent, 3=Good, 2=Average, 1=Poor

1. How would you rate your overall experience with the physician described above thus far? _________________
2. How would you rate the way the physician has followed the terms set forth in the employment contract? _________________
3. How would you rate the physician's ability to communicate effectively with other physicians, nurses, patients, etc.? ______________
4. How would you rate the way the physician has been accepted by patients at your medical facility? ________________
5. How would you rate the way the physician has been welcomed by the local community? ________________

Please use the space provided below to make any positive statement or comment on any problem or concern that you have in regard to the physician described above.