☐ Check box if change in sponsorship or location

Appalachian Regional Commission

J-1 Placement Verification Form

Physician Name:_____

USCIS J-1 Visa Waiver Approval Date: _____ H-1(b) Visa Approval Date: _____

ARC Commitment Employment Start Date: _____ Transfer start date, if applicable:_____
* *The ARC three-year service commitment begins upon USCIS approval of the ARC J-1 Visa Waiver recommendation and no later than 90 days after said approval.*

Home Address:
Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Email: _____

Specialty: _____

Location of Medical Practice:
Street: _____

City: _____State: _____

County: _____

HPSA: _____

Phone: _____ Email: _____

List additional locations on a separate page, if applicable.

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, PROVIDE HEALTHCARE SERVICES AT THE STATED LOCATION(S) A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Physician Signature Date

_____
Physician Name Printed

I HEREBY CERTIFY THAT DOCTOR _____ PROVIDES A MINIMUM OF 40 HOURS PER WEEK OF HEALTHCARE SERVICES IN THE LISTED ARC HPSA LOCATION(S).

_____
Employer Name

_____ _____ _____ _____
Employer's Signature Date Phone Email

RETURN THIS FORM TO:
Fiona O'Brien, Paralegal
fobrien@arc.gov

SEND COPY TO ARC J-1 CONTACT IN REQUESTED STATE
List available at www.arc.gov