



PLACEMENT VERIFICATION FORM

J-1 Visa Waiver Approval Date: _____

GA Medical License Number: _____

H-1B Visa Approval Date: _____

Physician Medicaid Number: _____

Employment Start Date: _____

PHYSICIAN NAME: _____ Specialty: _____

Home Address: _____

Phone Number: _____ Email: _____

EMPLOYER NAME: _____

Employer Point of Contact (Name, Title): _____

Contact Phone: _____ Email: _____

Employer Mailing Address: _____

PRACTICE SITE NAME & ADDRESS(ES): _____ **HPSA / MUA ID#** _____

1) _____

2) _____

3) _____

4) _____

5) _____

I hereby certify that I provide medical care services for a minimum of forty (40) hours per week (or 80 hrs/2-wks) at the location(s) and in the discipline listed above and that all information contained in this report is true to the best of my knowledge and belief.

Signature of J-1 Physician

Date

I hereby certify that the aforementioned physician provides medical care services for a minimum of forty (40) hours per week (or 80 hrs/2-wks) at the location(s) and in the discipline listed above and that all information contained in this report is true to the best of my knowledge and belief.

Employer Signatory (Type/Print Name)

Title

Signature of Employer

Date

Please return this completed form to SORH within thirty (30) days following employment commencement, along with 1) copy of the physician’s H-1B visa approval notice from USCIS and 2) copy of Georgia medical license. It is the responsibility of the J-1 physician to notify SORH of any changes to the information above.