State Office of Rural Health and Primary Care
Georgia Department of Community Health
502 South Seventh Street
Cordele, GA 31015-1443
(229) 401-3090

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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.

Rev. 05/2019