J-1 Visa Waiver Approval Date: GA Medical License Number: H-18 Visa Approval Date: Physician Medicaid Number: Employment Start Date: Physician Medicaid Number: Privsicum Nume: Specialty: Home Address: Phone Number: Employment Start Date: Email: Contact Phone: Email: Employer Point of Contact (Name, Tite): Contact Phone: Contact Phone: Email: Practice Site Name & Adoressics): HPSA / MUA IDP 1	GEORGIA DEPARTMENT OF COMMUNITY HEALTH	State Office of Rural Health and Primary Care Georgia Department of Community Health 502 South Seventh Street Cordele, GA 31015-1443 (229) 401-3090
H-1B Visa Approval Date: Physician Medicaid Number: Employment Start Date: Specialty: Physician NAME: Specialty: Home Address: Phone Number: Phone Number: Email: Contract (Name, Tub): Email: Employer Point of Contact (Name, Tub): Email: Contact Phone: Email: PRACTICE SITE NAME & ADDRESS[ES]: HPSA / MUA ID# 1)	PLACEMENT VERIFICATION FORM	
Employment Start Date:	J-1 Visa Waiver Approval Date:	GA Medical License Number:
PHYSICIAN NAME:	H-1B Visa Approval Date:	Physician Medicaid Number:
Home Address:	Employment Start Date:	
Phone Number: Email: EMPLOYER NAME:	Physician Name:	Specialty:
EMPLOYER NAME:	Home Address:	
Employer Point of Contact (Name, Title):	Phone Number: B	Email:
Contact Phone: Email: Employer Mailing Address: HPSA / MUA ID# 1)	Employer Name:	
Employer Mailing Address: HPSA / MUA ID# 1)	Employer Point of Contact (Name, Title):	
PRACTICE SITE NAME & ADDRESS(ES): HPSA / MUA ID# 1)	Contact Phone: I	Email:
1)	Employer Mailing Address:	
2)	PRACTICE SITE NAME & ADDRESS(ES):	HPSA / MUA ID#
2)	1)	
3)		
4)		
5)		
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		
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.		
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 J-1 Physician	Date
	80 hrs/2-wks) at the location(s) and in the discipline	
Signature of Employer Date	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.