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

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. 02/2024