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**Please check one:**

Conrad 30ARC

Current Employer New Employer

**Section 1-J-1 Physician’s Contact Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | DOS #: |  | | Name: |  | | | Home Address: | |  | | | | | Phone Number: |  | | Email Address: | |  | |

**Section 2-Original Employment Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  |  |  | | --- | --- | --- | --- | | Original Employer’s Name: |  | | | | Original Practice Site 1 Name: |  | | | | Original Practice Site 1 Address: |  | | | | Original Practice Site 2 Name: |  | | | | Original Practice Site 2 Address: |  | | | | Original Employer’s Contact Person’s Name: | |  | HPSA/MUA ID# : | | Original Employer’s Phone Number: |  | | | | Original Employer’s Email Address: |  | | | | **Last Date of Your Employment:** |  | | | |

**Section 3- New Practice’s Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | New Employer’s Name: (if applicable) |  | |  | |  | | 1st New Practice Site’s Name: |  | | | | | | New Practice Site’s Address: |  | | | | | | New Employer’s Contact Person’s Name: | |  | | | | | HPSA/MUA ID Number: |  | | | | | | New Practice Site’s Phone Number: |  | | | | | | New Employer’s Email Address: |  | | | | | | **Start Date of Your Employment:** |  | | |  |  |  |  |  | | --- | --- | | 2nd New Practice Site’s Name: |  | | New Practice Site’s Address: |  | | New Employer’s Contact Person’s Name: |  | | HPSA/MUA ID Number: |  | | New Practice Site’s Phone Number: |  | | New Employer’s Email Address: |  | | **Start Date of Your Employment:** |  | |

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**Section 4 J-1 Physician Certification**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| I certify that the above reported information is correct to the best of my knowledge and accurately reflects activities to the fulfillment of my obligation to the Virginia J-1 Visa Waiver Program.   |  |  |  | | --- | --- | --- | |  |  | | | Physician’s Printed Name |  | | |  |  | | | Signature | | Date | |

**Section 5- New Employer/Practice Site Endorsement**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| I hereby certify that Dr.       began practicing at       on       and provide 40 hours and no less than four days per week or 160 hours per month of direct patient care at the new practice site(s).    40 hours per week and no less than four days per week  160 hours per month   |  |  | | --- | --- | |  |  | | Printed Name | Title | |  |  | | Signature | Date | |

**Section 6- Returning to:**

Virginia Department of Health

Office of Health Equity  
109 Governor Street, Suite 714-W  
Richmond Virginia 23219

Phone: 804-864-7435   Fax: 804-864-7440

Email: [olivette.burroughs@vdh.virginia.gov](mailto:olivette.burroughs@vdh.virginia.gov)