Verification Of Employment (VOE)

Please select one:

☐ **Conrad 30** ☐ **ARC** **Reporting period from _____ to _____**

Section 1- J-1 Physician's Information

Physician: _____
First Name Middle Name Last Name

Physician's Home Address: _____
Street City State/Zip Code

J-1 DOS Case Number#: _____

Home/Cell Phone Number: _____ Email Address: _____

Actual Employment Start Date: _____

Section 2- J-1 Physician's Hours Worked per Month

Approved practice site 1:
I provide direct patient care at _____(Name of Practice Site)

Street Address: _____
City/State/Zip: _____
Telephone Number: _____
HPSA Number (include specific county/city, census tract, district, etc.): _____
Supervisor's Name: _____
Phone: _____ Email Address: _____

Month (Total hours- providing direct patient care)		Leave taken (#)	*Office Use only*
1st Month	_____	_____	
2nd Month	_____	_____	
3rd Month	_____	_____	
4th Month	_____	_____	
5th Month	_____	_____	
6th Month	_____	_____	

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Revised November 2017 – Updated 8/20/2019

Section 2- J-1 Physician's Hours Worked per Month

Approved practice site # 2 *(if applicable)*

I provide direct patient care at _____(Name of Practice Site)

Street Address: _____
City/State/Zip: _____
Telephone Number: _____
HPSA Number (include specific county/city, census tract, district, etc.): _____
Supervisor's Name:_____
Phone:_____ Email Address: _____

Month (Total hours- providing direct patient care)		Leave taken (#)	*Office Use only*
1st Month	_____	_____	
2nd Month	_____	_____	
3rd Month	_____	_____	
4th Month	_____	_____	
5th Month	_____	_____	
6th Month	_____	_____	

Section 3-Vacation and Leave

1. During the reporting period, I was absent from the practice for _____ days due to
   - ☐ illness
   - ☐ vacation or
   - ☐ other: (List and explain:)

2. Please provide us with your contract addendum if the absent for more than the allowable time as stated in your contract in order to meet J-1 Requirements. Did you attach the required addendum to your VOE form?
   ☐ Yes ☐ No *If No, VOE will be declined if service obligation is not completed in accordance with the contract and the policy requirement.

Section 4- Statistics for this Reporting Period

a. number of office visits (do not include telephone consultations or hospital visits): _____
b. number of visits from 4a who reside in a HPSA or MUA: _____
c. number of hospital visits: _____
d. number of patient visits for which a Medicare claim was submitted: _____ (Medicare# _____)
e. number of patient visits for which a Medicaid claim was submitted: _____ (Medicaid#)
f. number of patients wherein services were rendered at a sliding scale fee: _____
g. number of patient visits for which no charge was made (based on inability to pay): _____

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Section 5- 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 Name (Print or Type) Date

Original Physician's Signature

Section 6- Employer/Practice site Endorsement

I have reviewed the above report being submitted by _____ who began his/her practice with us on _____.
To the best of my knowledge, the information is accurate and correct.

Organization: Date:

Printed Name Title:

Phone Number Email

Original Signature:

The form must be completed, and signed by the physician and company's chief entity.

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VOE Instructions – 'How to Complete a VOE'

The 6-Month VOE Report

Section 1- J-1 Physician's Information

- Please follow the 1st 30-Day VOE Report beginning instructions including instructions for **Section 1- J-1 Physician's Information**.
- Please note, that your reporting period will start with your employment start date as in the example of 9/1/2019 on the 1st 30-Day VOE report example and will end 6-months out from your employment start date. **Do not start your 6-month report** with the following month after your employment start date. Please see example below:

Verification of Employment (VOE)

Please select one:

☒ **Conrad 30** ☐ **ARC** **Reporting period from** 09/01/2019 **to** 03/01/2020

Section 2- J-1 Physician's Hours Worked per Month

- Please complete all fields for **'Approved practice site 1':**
- Please note, if you work at 2 practice sites, you must complete all fields for **'Approved practice site 1 and Approve practice site 2'** and provide total monthly hours for each practice site separately. Your VOE will not be accepted if you ~~combine your work hours under one practice site~~.
- In section 2, in the shaded boxes for **'Month (Total hours – providing direct patient care'** double click the shaded boxes to type in your monthly hours total starting with the 1st Month all the way through to the six month.
    - Please do not make any edits to the columns with the outlined months, 1st, 2nd, 3rd, etc.

Please see example:

Approved practice site 1:

I provide direct patient care at Antioch Memorial Hospital(Name of Practice Site)
Street Address: 111 Anywhere Street (Your Practice Site Address)
City/State/Zip: Practice Site City, VA 99999
Telephone Number: xxx-xxx-xxxx
HPSA Number (include specific county/city, census tract, district, etc.):
Supervisor's Name: Your Supervisor's Name
Phone: Your Supervisor's Tel. # Email Address: Your Supervisor's Email

Month (Total hours- providing direct patient care)		Leave taken (#)	*Office Use only*
Do not Make Changes to this Column			
1st Month	160		
2nd Month	160		
3rd Month	160		
4th Month	160		
5th Month	160		
6th Month	160		

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Approved practice site # 2 *(if applicable)*:

I provide direct patient care at Antioch Medical Center (Name of Practice Site)
Street Address: 222 Anywhere Street (Your Practice Site Address)
City/State/Zip: Practice Site City, VA 99999
Telephone Number: xxx-xxx-xxxx
HPSA Number (include specific county/city, census tract, district, etc.):
Supervisor's Name: Your Supervisor's Name
Phone: Your Supervisor's Tel. # Email Address: Your Supervisor's Email

Month (Total hours- providing direct patient care)		Leave taken (#)	*Office Use only*
Do not Make Changes to this Column			
1st Month	160		
2nd Month	160		
3rd Month	160		
4th Month	160		
5th Month	160		
6th Month	160		

Section 2- J-1 Physician's Hours Worked per Month (continued)

- In the '**Leave taken (#)'** column please type the hours of leave taken. If you work at 2 practice sites, you must provide leave taken for both sites. Please see example:

Approved practice site 1:

I provide direct patient care at Antioch Memorial Hospital(Name of Practice Site)
Street Address: 111 Anywhere Street (Your Practice Site Address)
City/State/Zip: Practice Site City, VA 99999
Telephone Number: xxx-xxx-xxxx
HPSA Number (include specific county/city, census tract, district, etc.):
Supervisor's Name: Your Supervisor's Name
Phone: Your Supervisor's Tel. # Email Address: Your Supervisor's Email

Month (Total hours- providing direct patient care)		Leave taken (#)	*Office Use only*
1st Month		8	
2nd Month		0	
3rd Month		4	
4th Month		0	
5th Month		80	
6th Month		3	

Approved practice site # 2 *(if applicable)*:

I provide direct patient care at Antioch Medical Center (Name of Practice Site)
Street Address: 222 Anywhere Street (Your Practice Site Address)
City/State/Zip: Practice Site City, VA 99999
Telephone Number: xxx-xxx-xxxx
HPSA Number (include specific county/city, census tract, district, etc.):
Supervisor's Name: Your Supervisor's Name
Phone: Your Supervisor's Tel. # Email Address: Your Supervisor's Email

Month (Total hours- providing direct patient care)		Leave taken (#)	*Office Use only*
1st Month		8	
2nd Month		0	
3rd Month		4	
4th Month		2	
5th Month		80	
6th Month		0	

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Sections 3, 4, 5, and 6

- Please follow the same instructions in the 1st 30-Day VOE for Sections 3, 4, 5, and 6.

VOE Calculation for Determining Completion of Service Obligation for VA Conrad-30 J-1 Waiver Program

The J-1 physician has met the service obligation when they have completed a 3-year service term based on the following hourly calculation:

- 6 months x 160 scheduled work hours = 960 work hours

  960 work hours (total hours for 6-mo.) x 6 months = 5,760 work hours

A J-1 physician has met the 3-year service obligation when they have worked 5,760 hours or more over a 3-year term. If the J-1 physician is short in hours, they will be required to make up the time as appropriate.

The 30-day and 6-month VOE should be submitted to VDH within 2 weeks of the end period reporting date. The Health Workforce Coordinator will provide a reminder when the next VOE is due. It is the J-1 physician's responsibility to ensure that their VOE is submitted timely and accurately to our office.

At the end of the J-1 physician's 3-year term, our office will prepare a completion letter that will be mailed to the physician's most current mailing address on file. In order to prepare the completion letter, the J-1 Physician must have all VOE's on file to verify that he/she has met the service obligation.

If you have any questions regarding the VOE process, please do not hesitate to contact our office at (804) 864-7435 or contact Olivette Burroughs, Health Workforce Specialist at (804) 864-7413, or email: olivette.burroughs@vdh.virginia.gov or email our office at incentiveprograms@vdh.virginia.gov.

Please Note: When submitting the VOE Report, do not include the 'The How to Complete the VOE' Instructions. Thank you!

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