VDH VIRGINIA DEPARTMENT OF HEALTH

Virginia Health Workforce Incentive Programs

30-day Verification of Employment Form (VOE)

Please submit the completed form, along with a copy of the physician's USCIS approval notice, to incentiveprograms@vdh.virginia.gov upon completion of initial thirty-day period of employment.

Please Select One:	☐ **Conrad 30**	☐ **ARC**
U.S. Department of State Case Number:		
Employment Start Date:		
Physician Information: Enter information for the physician. **Do not enter email or physical addresses routed to the physician's former school, or current practice site.**	Physician's Full Name:	
	Physician's Specialty:	
	Street Address:	
	City:	State:
	Zip:	County:
	Email:	Phone Number:
Employer Information: Enter information for the physician's employer.	Organization's Name:	
	Supervisor's Name:	
	Supervisor's Title:	
	Phone Number:	
	Email:	
Practice Site Information Enter information for site where the physician provides direct patient care. **Do not enter information for your organization's headquarters or central office.**	Practice Site Name:	
	Street Address:	
	City:	State:
	Zip:	County:
HPSA/MUA ID #		

Virginia Department of Health, Office of Health Equity
109 Governor Street, Richmond, Virginia 23219
Email: **incentiveprograms@vdh.virginia.gov**

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Practice Site Information Enter information for site where the physician provides direct patient care. **Do not enter information for your organization's headquarters or central office.**	Practice Site Name:	
	Street Address:	
	City:	State:
	Zip:	County:
HPSA/MUA ID #		

Physician Certification:

I certify that the above reported information is correct to the best of my knowledge and that I provide medical care services for a minimum of 40 hours per week or 160 hours per month.

_____ _____

Physician's Signature Date

Practice Site Endorsement:

I hereby certify that the physician named above is providing medical care services for a minimum of forty (40) hours per week, or the equivalent of one hundred sixty (160) hours per month, at the approved practice location(s) and in the discipline listed on this form. I further attest that all information provided in this report is true and accurate to the best of my knowledge and belief.

_____ _____

Employer's Name Title

_____ _____

Employer's Signature Date

Please submit this completed form to incentiveprograms@vdh.virginia.gov within thirty (30) days following employment commencement, along with a copy of the physician's approval notice from USCIS. It is the responsibility of the J-1 physician to notify VDH-OHE of any changes to the information above.