VDH VIRGINIA DEPARTMENT OF HEALTH

Virginia Health Workforce Incentive Programs

6 Month Verification of Employment Form (VOE)

Please submit the completed form to incentiveprograms@vdh.virginia.gov upon completion of six-month period of employment.

Please Select One:	☐ **Conrad 30**	☐ **ARC**
Reporting period: _____ **to** _____		
U.S. Department of State Case Number:		
Employment Start Date:	**Total Leave Taken During Period:**	

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:	
	Home Address:	
	City:	State:
	Zip:	County:
	Email:	Phone Number:

Supervisor Information: Enter information for the physician's employer.	Practice Site 1:	
	Supervisor's Name:	
	Supervisor's Title:	
	Phone Number:	
	Email:	

Direct Patient Care Hours (Site #1)		**Practice Site #1:** Enter information for site where the physician provides direct patient care.	
Month 1		Site Name:	
Month 2		Street Address:	
Month 3		City:	State:
Month 4		Zip:	County:
Month 5		HPSA/MUA ID:	
Month 6		Leave Taken (Hours)/Leave Type:	

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

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Supervisor Information: Enter information for the physician's employer.	Practice Site 2:
	Supervisor's Name:
	Supervisor's Title:
	Phone Number:
	Email:

Direct Patient Care Hours (Site #2)		**Practice Site 2:** Enter information for site where the physician provides direct patient care.
Month 1		Site Name:
Month 2		Street Address:
Month 3		City: State:
Month 4		Zip: County:
Month 5		HPSA/MUA ID:
Month 6		Leave Taken (Hours)/ Leave Type:

Physician Certification:

I certify that the information provided above is accurate to the best of my knowledge. I further affirm that I provide medical care services for a minimum of 40 hours per week or 160 hours per month. I understand that if any leave taken results in my falling below this requirement, I will make up the necessary hours to remain in compliance. I further understand that if I am absent for more than the allowable time listed in my employee contract a contract addendum is required to meet J-1 requirements.

_____ _____

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. It is the responsibility of the J-1 physician to notify VDH-OHE of any changes to the information above.

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