

J-1 VISA PHYSICIAN REPORTING FORM

To be submitted on a semi-annual basis (every 6 months) during the three (3) year service obligation

Physician Statement

DATE:

Physician Name:

Home Address:

City:

State:

Zip Code:

Office Address:

City:

State:

Zip Code:

Type of Medical Practice:

Physical Address of Medical Practice:

City:

State:

Zip Code:

County:

I hereby certify that I, the undersigned, do provide primary healthcare services at the above stated address a minimum of forty (40) hours per week.

Physician's Signature

Employer Statement

DATE:

I, _____ do hereby certify
Doctor _____, is employed by
_____, and provides forty
(40) hours of primary healthcare services per week.

Employer's Authorized Signature

Printed Name, Title

Return Completed Form To:

Keri Wagner
Office of Rural Health
Wyoming Department of Health
6101 Yellowstone Road, Suite 420
Cheyenne, WY 82002