Attachment B

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:

Personal E-mail Address:

Office Address:

City: State: Zip Code:

Office E-mail Address:

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

_____
E-mail Address

Return Completed Form To:

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Office of Rural Health
Public Health Division
Wyoming Department of Health
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Cheyenne, WY 82002
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