Verification Form

Physician Name
Phone
Fax
Email

Employer Name
Phone
Fax
Email

Facility Name
Facility Address
HPSA ID

By signing this form, I confirm that the J-1 Physician,_____, started full time employment at _____ on _____ which is within ninety (90) days of receiving approval from USCIS on _____.

_____ _____
Employer Signature Date

_____ _____
Physician Signature Date