



Northern Border Regional Commission

J-1 Transfer Notification Form

Physician Name: _____

Home Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Home Phone: _____

Sponsor Name: _____

Present Location of Medical Practice:

Street: _____

City: _____ State: _____

County: _____

HPSA: _____

Phone: _____

Date of Transfer: _____

Sponsor Name: _____

New Location of Medical Practice:

Street: _____

City: _____ State: _____

County: _____

HPSA: _____

Phone: _____

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE SERVICES AT THE NEW LOCATION A MINIMUM OF 40 HOURS PER WEEK.

Physician Signature
(Notary)

Date

I HEREBY CERTIFY THAT DOCTOR _____ PROVIDES PRIMARY HEALTH CARE SERVICES AT THE NEW ARC HPSA LOCATION A MINIMUM OF 40 HOURS PER WEEK.

Sponsor Signature
(Notary)

Date