



Northern Border Regional Commission

J-1 Placement Verification Form

Physician Name: _____

USCIS J-1 Visa Waiver Approval Date: _____ H-1(b) Visa Approval Date: _____

NBRC Commitment Employment Start Date: _____ Transfer start date, if applicable: _____

** The NBRC three-year service commitment begins upon USCIS approval of the NBRC J-1 Visa Waiver recommendation and no later than 90 days after said approval*

Home Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Type of Medical Practice: _____

Location of Medical Practice:

Street: _____

City: _____ State: _____

County: _____

HPSA/MUA: _____

Phone: _____ Email: _____

Additional locations (if applicable)

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE SERVICES AT THE ABOVE STATED LOCATION(S) A MINIMUM OF 40 HOURS PER WEEK.

Physician Signature

Date

Physician Name Printed

I HEREBY CERTIFY THAT DOCTOR _____ PROVIDES A MINIMUM OF 40 HOURS PER WEEK OF PRIMARY HEALTH CARE IN THE ABOVE LISTED NBRC HPSA/MUALLOCATION(S).

Employer's Signature

Date

Phone

Email

Employer's Name Printed

RETURN THIS FORM TO:
Liz Cross, Rural Healthcare Coordinator, j1visa@nbrc.gov

SEND COPY TO NBRC J-1 CONTACT IN REQUESTED STATE
List available at www.nbrc.gov