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: _____ (within 90 days of USCIS approval of NBRC J-1 Visa Waiver request)

Home Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Type of Medical Practice: _____

Location of Medical Specialty:

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 (Notary) Date

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

Sponsor Signature (Notary) | Date | Phone | Email

_____
Printed Name

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