The Delta Regional Authority
J-1 Visa Waiver Program

Physician Employment Verification Form

- **This form is not to be submitted with the waiver application, but is to be completed and mailed to the DRA within the physician's first week of practice.**

- **Include copies of the physician's state medical license with this form if they were not included / available at the time the J-1 Waiver Application was submitted. Also include copies of I-94 renewals and approval notices with this document.**

- **If the physician will be providing services for the employer at different sites than the office site listed below, please provide those addresses on a separate page and attach to this form.**

PHYSICIAN:

Name: (print or type)_____Employment Start Date:_____

I-612 Approval Date: _____

H-1(b) Approval Date: _____

Address: Home:_____ Office:_____
Street Street

_____ _____
City/State/Zip City/State/Zip

_____ _____
Home Phone Work Phone

Physician's E-mail Address: _____

I hereby certify that I, the undersigned, do provide primary health care services at the above stated address for a minimum of 40 hours per week.

Physician's signature_____ Date:_____

EMPLOYER:

Name of Health Care Facility:_____

Address:_____
Street/Location City/State/Zip County

Type of Medical Practice:_____
(Example: General Practice, Family Medicine, Pediatrics, etc.)

Point of Contact Name & Phone Number: _____

Point of Contact E-mail Address:_____

I do hereby certify that Doctor _____ is

employed by _____

and provides 40 hours of primary health care per week at the above stated address.

_____
Employer's signature Print/type employer's name and title Date

Please Return Form(s) To:

The Delta Regional Authority
Attention: Justin Ferguson
236 Sharkey Avenue, Suite 400
Clarksdale, MS 38614