

## Kentucky J-1 Visa Waiver Program Placement Verification Form

Physician Name: \_\_\_\_\_

INS J-1 Visa Waiver Approval Date: \_\_\_\_\_ H-1 (b) Approval Date: \_\_\_\_\_

Initial Employment Start Date after the Approval of the J-1 Visa Waiver \_\_\_\_\_

Home Address:

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_

Name and Address of Primary Work Site:

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code \_\_\_\_\_

County: \_\_\_\_\_ HPSA \_\_\_\_\_ MUA \_\_\_\_\_

Phone: \_\_\_\_\_ FAX \_\_\_\_\_

Additional work sites: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Sponsor Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner/ CEO Signature

Return this form to: Gary Williams, KY J-1 Visa Waiver Program Administrator  
Health Care Access Branch, Dept for Public Health  
275 E. Main St. , HS2WB  
Frankfort, KY 40621