INDIANA STATE-30 J-1 VISA WAIVER PROGRAM
VERIFICATION OF EMPLOYMENT

Reporting period from _____to _____
(Please report for the full amount of time at the sponsoring facility)

PHYSICIAN:

_____
First Name *Middle Name* *Last Name*

_____
Street *City* *State* *Zip*

Social Security # _____ J-1 Visa Waiver #_____H1B #_____

Passport #_____

Home Phone Number: _____ Email Address: _____

BCIS Approval Date or Actual Employment Start Date, whichever is later.
_____
(If more than one medical practice address, please attach separate sheet)

1. I maintain a full-time clinical practice at:

   Name of Medical Practice:
   _____
   Street Address:
   _____
   City/State/Zip:
   _____
   Telephone Number:
   _____
   HPSA (include specific county/city, census tract, district, etc.):
   _____

2. During the reporting period, I maintained office hours (use "X" for days not usually practicing). DO NOT include "on-call" status time.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From:							
To:							

3. During the reporting period, approximately _____hours/week were required to treat hospitalized patients of the practice at _____ Hospital.

4. During the reporting period, I was absent from the practice for_____days due to illness, vacation, or for continuing professional education.
5. For this reporting period:
    a. Number of office visits (excluding phone consultations or hospital visits)_____
    b. Number of visits from 5a who reside in a Health Professional Shortage Area _____
    c. Number of hospital visits _____
    d. Number of patient visits for whom a Medicare claim was submitted _____
    e. Number of patient visits for whom a Medicaid claim was submitted _____
    f. Number of patients wherein services were rendered at a rate less than usual customary fee _____
    g. Number of patient visits for which no charge was made (per inability to pay)_____

6. My Medicare Provider Number is:_____

7. My Medicaid Provider Number is:_____

CERTIFICATION

I CERTIFY THAT THE ABOVE REPORTED INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND ACCURATELY REFLECTS ACTIVITIES TO THE FULFILLMENT OF MY OBLIGATION TO THE MONTANA J-1 VISA WAIVER PRGORAM.

_____
Physician's Name: (Print or Type)

_____
Physician's Signature Date

ENDORSEMENT

I HAVE REVIEWED THE ABOVE REPORT BEING SUBMITTED BY_____WHO BEGAN HIS/HER PRACTICE WITH US ON _____. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IS ACCURATE AND CORRECT.

Organization: _____Date: _____

Signature:_____ Title: _____

RETURN THIS FORM TO:
Indiana State Department of Health
Primary Care Office
2 North Meridian, 2J
Indianapolis, IN 46204