J-1 Physician Visa Waiver Program Change of Practice Discipline

J-1 Physician Name: _____ Email: _____

Cell Phone: (____) _____ E-mail address: _____

Current Practice Address: _____ Telephone #: _____

Proposed Start Date at New Facility: ___/___/___ Proposed Provider Discipline:_____

Original J-1 Waiver Start Date: ____/___/___ Anticipated End Date: ___/___/___

Reason for transfer or change of practice location or discipline: _____

_____

_____

Please list the proposed work assignments (include clinic call, hospital rounding, and emergency room or hospital call)

Address(s) of Proposed Work Assignment(s)	**HPSA or MUA/MUP ID#**	**Number of Hours per week**

_____

Signature of Site/Facility Executive Director/CEO Date

I hereby certify that I, the undersigned, will provide primary health care or specialty services at the above-stated address(s) a minimum of 40 hours per week for three years. Deviation from such site may result in notification by the Nevada Division of Public and Behavioral Health to appropriate federal agencies.

_____

Physician's Signature Date

Return Completed Form and Any Documents by Email:

to nvpco@health.nv.gov