

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