



2012 J-1 VISA WAIVER PROGRAM
Request For Letter of Support
PHYSICIAN APPLICATION

PROGRAM APPLYING FOR: [] PRIMARY CARE [] SPECIALTY
(SELECT ONE ONLY)

NAME (Last) (First) (Middle Initial) (DOS Case Number)

LANGUAGES SPOKEN FLUENTLY:

CURRENT MAILING ADDRESS (Street Address) (Apt Number) (City) (State) (Zip)

PHONE NUMBER: Home: () Other: ()

E-Mail:

EMPLOYER (If different from the service site):

CONTACT PERSON:

MAILING ADDRESS: (City) (State) (Zip)

PHONE NUMBERS: () Main () Fax

E-Mail:

SERVICE SITE*: (NAME)

PHYSICAL ADDRESS (Street Address) (City) (State) (Zip)

MAILING ADDRESS (if different from street address) (City) (State) (Zip)

*IF APPLICABLE, LIST ALL ADDITIONAL SERVICE SITES ON SEPARATE SHEET AND ATTACH TO PHYSICIAN APPLICATION.

SERVICE DATES (anticipated) MM/DD/YY TO MM/DD/YY

2012 PROGRAM EXPECTATIONS FOR THE J-1 PHYSICIAN

B. THE J-1 PHYSICIAN UNDERSTANDS THAT:

1. The review of this request is discretionary and that in the event a decision is made not to grant my request, I hold harmless the Arizona Department of Health Services, and any and all employees, agents, and assigns for any action or lack of action in connection with this request.
2. The entire basis for the consideration of my request is the voluntary policy of the Department and its desire to improve the availability of medical care in regions designated by the U.S. Public Health Services as health professional shortage areas or medically underserved areas or populations.
3. Any employment agreement I enter pursuant to paragraph (A)(1) shall not contain any provision, which modifies or amends any of the essential terms of the program's requirements or expectations.
4. My services rendered pursuant to paragraph (A)(1) shall be in a Medicare certified facility which has an open, non-discriminatory admission policy and that will accept AHCCCS, Medicare/Medicaid and SCHIP assignments.

Signature of foreign physician

Date

State of _____)

County of _____)

The foregoing instrument was acknowledged before me this _____

Date

by _____.

Printed name of foreign physician

Signature of person taking acknowledgment

Title or rank

Serial number, if any