

**Ohio Department of Health
State 30 J-1 Visa Waiver Program
Verification of Employment Form**

This form is required to be submitted within 30 days of employment start date.

I. PHYSICIAN INFORMATION

Name: _____

Phone Number: _____ E-mail Address: _____

USCIS J-1 Visa Waiver Approval Date: _____
(Attach copy)

H-1(b) Visa Approval Date: _____
(Attach copy)

Employment Start Date: _____

II. PRACTICE SITE INFORMATION

If practicing at more than one site, please provide corresponding information on additional page(s).

Name: _____

Address: _____

City: _____ State _____ Zip Code: _____

Number of hours per week: _____ Specialty: _____

III. CERTIFICATIONS

I HEREBY CERTIFY THAT I PROVIDE DIRECT PATIENT CARE AT THE APPROVED SITES(S) FOR A MINIMUM OF 40 HOURS PER WEEK.

Physician Signature

Date

I HEREBY CERTIFY THAT DOCTOR _____ PROVIDES DIRECT PATIENT CARE FOR A MINIMUM OF 40 HOURS PER WEEK AT THE APPROVED SITE(S).

Sponsor Name (Print)

Sponsor Title

Phone Number

Sponsor Signature

Date

E-mail Address

MAIL THIS FORM TO:
Ohio J-1 Visa Waiver Program
Ohio Department of Health
246 N. High Street – 7th Floor
Columbus, Ohio 43215
Phone: (614) 466-1629