Maryland
DEPARTMENT OF HEALTH

J-1 Visa Waiver
Certification of Arrival to Practice Agreement

I, _____, a Physician participating in the Maryland J-1 Visa Waiver Program certify that I arrived for work at _____, on _____.

Current Contact Information:

Home Address:

Street:_____ City_____

State:_____Zip code:_____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Maryland Medical License Number: _____

Location of Medical Practice: _____
Street

_____
City State Zip

_____
Telephone Number

My Physician Supervisor will be: _____

_____
Signature of Supervising Physician Date

_____
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 a minimum of 40 hours per week for three years. Deviation from such site may result in notification of by Maryland Department of Health to appropriate federal agencies. I have a current Maryland medical license and have been thoroughly credentialed.

Physician's Signature Date

Return Completed Form To:

Maryland Department of Health
Office of Population Health Improvement
201 West Preston Street
Baltimore, MD 21201
Phone: 410-767-6123
mdh.providerworkforceprograms@maryland.gov