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 _____ (Name of Practice), on _____ (Start Date).

Physician, 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 Site: Street:_____

City:_____ State:___ Zip Code: _____

Phone Number: _____

My Physician Supervisor will be: _____

_____

Signature of Supervising Physician Date

Name of Site/Facility Executive Director/CEO: _____

_____

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. I have a current Maryland medical license and have been thoroughly credentialed. I understand that deviation from such may result in notification by the Maryland Department of Health to appropriate federal agencies.

_____

Physician's Signature Date

Return Completed Form To:

Workforce Coordinator
Maryland Department of Health
Office of Population Health Improvement
201 West Preston Street
Baltimore, MD 21201
Phone: 410-767-7141 ● Fax: 410-333-7501
mdh.providerworkforceprograms@maryland.gov

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