J-1 Visa Waiver Program Physician
Compliance Closing Survey

Note: Responses to the questions on this survey are strictly confidential. Only designated staff with the Commission will view the responses to the following questions.

Date: _____ Employment Start Date: _____

Name: (print or type) _____

Years Served: _____ Specialty: _____

Address: Home: _____ Work Site: _____
Street Street

_____ _____
City/State/Zip City/State/Zip

_____ _____
Home Phone Work Phone

**Please list additional work sites on the attached pages.*

Physician's E-mail Address: _____

Name of Employer: _____

Address: _____
Street/Location City/State/Zip County

Type of Medical Practice: _____
(Example: General Practice, Family Medicine, Pediatrics, etc.)

I hereby certify that I, the undersigned, provided direct patient care for the above listed employer for 40 hours per week, or 160 hours per month, at a worksite(s) located within a HPSA or MUA. I further attest that the information above is truthful and accurate.

I hereby acknowledge that all information and statements contained herein are true and do not misrepresent facts, per requirements of 18 USC 1001 (Title 18, U.S. Code, Part 1, Chapter 47, Section 1001). I further acknowledge that I have not evaded or suppressed any information contained in this document or in any of the supporting materials.

Physician's Signature: _____Date:_____

I hereby certify that doctor _____ provided direct patient care at the worksite(s) listed for forty (40) hours per week, or one hundred sixty (160) hours per month, for three (3) years.

Employer's Signature: **_____Date:** _____

Employer: _____ **Title:** _____

Please answer the following questions (Physician):

1. Rate your overall experience with the J-1 Visa Waiver program:

   ☐ Excellent ☐ Good ☐ Average ☐ Poor

2. Please list any suggestions you may have to improve the experience of the program.

3. Please list any suggestions you have that would have improved your work experience.

4. After your contracted term is complete, do you plan to continue working at the facility?

5. If not, where do you plan to locate and work next?

6. Would you continue to practice medicine? If so, what type of medicine would you practice?

7. Please list the reasons why you are leaving your current location.

8. Please list the reasons that would remain at your current location. (higher salary, becoming a partner in the facility, better community experience, etc.)

Please use the space below to make any positive statement or comment on any problem or concern that you have regarding your overall experience with the J-1 Visa Waiver program.

ADDITIONAL WORKSITES

Name: ____

Street: ____

City: __________________ State: __________Zip Code: ____________

County: ____

HPSA : ___________________________ MUA : __________________

Dates of Employment: _________________ to _____________________

Name: ____

Street: ____

City: __________________ State: __________Zip Code: ____________

County: ____

HPSA : ___________________________ MUA : __________________

Dates of Employment: _________________ to _____________________

Name: ____

Street: ____

City: __________________ State: __________Zip Code: ____________

County: ____

HPSA : ___________________________ MUA : __________________

Dates of Employment: _________________ to _____________________

Name: ____

Street: ____

City: __________________ State: __________Zip Code: ____________

County: ____

HPSA : ___________________________ MUA : __________________

Dates of Employment: _________________ to _____________________