J-1 Visa Waiver Program

Physician Compliance Survey Part A (Employer)

Note: Responses to the questions listed on pages two and three are strictly confidential. Only designated staff with the Southeast Crescent Regional Commission will view the responses to those questions.

Year: _____ Survey Number: _____

Survey Period: _____ Survey Date: _____

Name of Physician: _____

I-612 Approval Date: _____

H-1(b) Approval Date: _____

Employment Start Date: _____

Name of Employer: _____

Point of Contact: _____

Phone Number: _____

E-mail Address: _____

Name of Worksite (Please provide data for each worksite): _____

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

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

Please indicate the number of patients that the **physician** has treated in the past six months.

Total No. of Patients: _____

No. of Private Pay Patients: _____ % of Total Patients: 0.00%

No. of Medicare Patients: _____ %of Total Patients: 0.00%

No. of Medicaid Patients: _____ % of Total Patients: 0.00%

No. of Indigent Patients: _____ % of Total Patients: 0.00%

No. of Other Patients: _____ % of Total Patients: 0.00%

Please indicate the number of patients that the **facility** has treated in the past six months.

Total No. of Patients: _____

No. of Private Pay Patients: _____ % of Total Patients: 0.00%

No. of Medicare Patients: _____ %of Total Patients: 0.00%

No. of Medicaid Patients: _____ % of Total Patients: 0.00%

No. of Indigent Patients: _____ % of Total Patients: 0.00%

No. of Other Patients: _____ % of Total Patients: 0.00%

Please answer the following questions in accordance with the indicated scale:

4=Excellent, 3=Good, 2=Average, 1=Poor

1. How would you rate your overall experience with the physician described above thus far? _____
2. How would you rate the way the physician has followed the terms set forth in the employment contract? _____
3. How would you rate the physician's ability to communicate effectively with other physicians, nurses, patients, etc.? _____
4. How would you rate the way the physician has been accepted by patients at your medical facility? _____
5. How would you rate the way the physician has been welcomed by the local community? _____

Please use the space provided below to make any positive statement or comment on any problem or concern that you have regarding the physician described above.

I do hereby certify that Doctor _____ is employed by _____ and provides 40 hours of direct patient care per week, or 160 hours per month.

_____	_____	_____
Employer's Signature	Employer's Name and Title	Date

J-1 Visa Waiver Program

Physician Compliance Survey Part B (Physician)

Note: Responses to the questions listed on page two and three are strictly confidential. Only designated staff with the Southeast Crescent Regional Commission will view the responses to those questions.

Year: _____ Survey Number: _____

Survey Period: _____ Survey Date: _____

Name: (print or type)_____

Employment Start Date: _____

I-612 Approval Date: _____

H-1(b) Approval Date: _____

Address: Home: _____ Office:_____
Street Street

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

_____ _____
Home Phone Work Phone

Physician's E-mail Address: _____

Name of Worksite (Please provide data for each worksite): _____

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

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

Please indicate the number of patients that **you** have seen in the past six months.

Total No. of Patients: _____

No. of Private Pay Patients: _____ % of Total Patients: 0.00%

No. of Medicare Patients: _____ %of Total Patients: 0.00%

No. of Medicaid Patients: _____ % of Total Patients: 0.00%

No. of Indigent Patients: _____ % of Total Patients: 0.00%

No. of Other Patients: _____ % of Total Patients: 0.00%

Please indicate the number of patients that the **facility** has treated in the past six months.

Total No. of Patients: _____

No. of Private Pay Patients: _____ % of Total Patients: 0.00%

No. of Medicare Patients: _____ %of Total Patients: 0.00%

No. of Medicaid Patients: _____ % of Total Patients: 0.00%

No. of Indigent Patients: _____ % of Total Patients: 0.00%

No. of Other Patients: _____ % of Total Patients: 0.00%

Please answer the following questions in accordance with the indicated scale:

4=Excellent, 3=Good, 2=Average, 1=Poor

1. How would you rate your overall experience with the medical facility described above thus far? _____

2. How would you rate the way the administrator(s) of the medical facility has followed the terms set forth in the employment contract? _____

3. How would you rate the way that you have been treated by the administrator(s) of the medical facility described above? _____

4. How would you rate the way you have been accepted by patients at the medical facility described above? _____

5. How would you rate the way you have been welcomed by the local community? _____

Please use the space provided to make any positive statement or comment on any problem or concern that you have regarding the medical facility listed above.

I hereby certify that I, the undersigned, do provide direct patient care at the above stated worksite(s) for 40 hours per week, or 160 hours per month. I further attest that the information above is truthful and accurate.

Physician's Signature_____ Date:_____