

STATE OF MICHIGAN

J-1 Visa Waiver Physician Change of Status Form

Name of J-1 Visa Waiver Physician: _____

Medical Practice Name and Address:

I hereby declare and certify that a change in status has occurred with the J-1 Visa Waiver Physician named above. This status has changed for the following reason (Check One):

The physician has fulfilled his/her three-year employment obligation required by the waiver, and no longer is employed by us. Completion Date: _____

An additional site has been added (please include new site(s), address(es), and HPSA#).

The physician has transferred employment sites and continues to be employed at a qualifying site (please include new site(s), address(es), and HPSA#).

Authorized Signature of
Facility Administration

(____)____-____
Telephone Number

Date

Return to: Michigan Health Council
2410 Woodlake Drive, Suite 440
Okemos, MI 48864