FY 2023 **Attachment 5**

STATE OF MICHIGAN

J-1 Visa Physician Employment Report Form

Name of J-1 Visa Waiver Physician: _____

Medical Practice Name and Address:

I hereby declare and certify that _____ is no longer employed for at least
(Physician)

40 hours per week by _____ at the above-stated address. The
(Name of facility/Organization)

reason for this change in employment status is due to the following (Check One):

Employee has freely chosen to discontinue employment with the organization.

The organization has terminated the employee's contract. (If this is checked, please provide a detailed justification below—Include attachments if necessary.)

_____	_____	_____
Authorized Signature of Facility Administration	Telephone Number	Date

Notary:

_____	_____
Signature	Date

Return to: Michigan Department of Health and Human Services
P.O. Box 30195
Lansing, MI 48909