

J-1 VISA WAIVER PROGRAM
Request For Letter of Support
PHYSICIAN APPLICATION

PROGRAM APPLYING FOR: (SELECT ONE ONLY)

PRIMARY CARE

SPECIALTY

NAME

(Last)

(First)

(Middle Initial)

(DOS Case Number)

LANGUAGES SPOKEN FLUENTLY:

CURRENT MAILING ADDRESS

(Street Address)

(Apt Number)

(City)

(State)

(Zip)

PHONE NUMBER: Home: ()

Other: ()

E-Mail:

EMPLOYER (If different from the service site):

CONTACT PERSON:

MAILING ADDRESS:

(City)

(State)

(Zip)

PHONE NUMBERS:

()

()

Main

Fax

E-Mail:

SERVICE SITE*: (NAME)

PHYSICAL ADDRESS

(Street Address)

(City)

(State)

(Zip)

MAILING ADDRESS (if different from street address)

(City)

(State)

(Zip)

**IF APPLICABLE, LIST ALL ADDITIONAL SERVICE SITES ON SEPARATE SHEET AND ATTACH TO PHYSICIAN APPLICATION.*

SERVICE DATES (anticipated)

MM/DD/YY

TO

MM/DD/YY

