



2010 J-1 VISA WAIVER PROGRAM
Request For Letter of Support
PHYSICIAN APPLICATION

PROGRAM APPLYING FOR: [] PRIMARY CARE
(SELECT ONE ONLY)

[] 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

