J-1 Transfer Notification Form

Physician Name: _____

Home Address:
Street: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____

Home Phone: _____
Sponsor Name: _____

Present Location of Medical Practice:

Street: _____
City: _____State: _____
County: _____
HPSA: _____
Phone: _____

Date of Transfer: _____

Sponsor Name: _____

New Location of Medical Practice:

Street: _____
City: _____State: _____
County: _____
HPSA: _____
Phone: _____

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE SERVICES AT THE NEW
LOCATION A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Physician Signature Date
(Notary)

I HEREBY CERTIFY THAT DOCTOR _____ PROVIDES PRIMARY HEALTH CARE SERVICES AT THE NEW ARC HPSA LOCATION A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Sponsor Signature Date
(Notary)