ATTACHMENT C

Certification of Arrival to Practice and Report Agreement

I _____, a Physician participating in the New Mexico J-1 Visa Waiver

Program certify that I have arrived for work at _____, on _____.

Updated Information:

Home Address: _____

Home Phone: _____ Business Phone: _____

Home Email: _____ Business Email: _____

New Mexico Medical License Number: _____

My Physician Supervisor Name: _____

_____ _____

Supervising Physician Signature **Date**

_____ _____

Site/Facility Executive Director/CEO Signature **Date**

Location of Medical Practice: _____

Street

_____

City State Zip

_____

Telephone Number

I hereby certify that I, the undersigned, will provide primary health care or specialty services at the above stated address a minimum of 40 hours per week for 3 years. Deviation from such site may result in notification by NMDOH to appropriate federal agencies. I have a current New Mexico medical license and have been thoroughly credentialed.

_____

Physician's Signature **Date**

Return Completed Form to:

Melanie Keams, Program Coordinator by email at MelanieJ.Keams@doh.nm.gov, or by physical mail:
J-1 Visa Waiver Program
Office of Primary Care and Rural Health
5300 Homestead Rd. NE
Albuquerque, New Mexico 87110