

**South Dakota Department of Health
Office of Rural Health
J-1 Visa Waiver Annual Report Form**

Please complete this form after the J-1 physician has completed their first year of employment, and yearly thereafter, as required by ARSD 44:63:04:01. Within two weeks mail to:

Josie Petersen
SD Office of Rural Health
600 East Capitol Avenue
Pierre, SD 57501

Physician's name: _____

Beginning date of employment: _____

Physician's employment address: _____

Physician's employment phone number: _____

Physician's practice sites and time spent at each: _____

Have there been any changes to the J-1 physician's practice location(s) from the original employment contract or addendum approved by the SD Department of Health? Yes _____ No _____

If yes, please state the practice location changes. _____

Have there been any changes in the J-1 physician's employment status? Yes _____ No _____

If yes, please state the employment status changes. _____

CEO or representative of employing facility signature

Date

CEO or representative of employing facility printed

Physician signature

Date

Physician name printed