

**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: Jill Dean

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

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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