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 the first year of employment, and yearly thereafter, as required by ARSD 44:63:04:01. Return form to:

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

J-1 Physician's name: _____

Beginning date of employment: _____

J-1 Physician's employment address: _____

_____

J-1 Physician's employment phone number: _____

J-1 Physician's practice sites and time spent at each: _____

_____

Have there been any changes to the J-1 physician's practice location 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 to the J-1 physician's employment status? Yes ☐ No ☐

If yes, please state the employment status changes. _____

_____

In the past year, what percentage of patients seen by the J-1 physician were Medicaid insured? _____

_____
CEO of Facility Representative Name (Printed)

_____ _____
CEO of Facility Representative Name (Signature) Date

_____ _____
J-1 Physician Signature Date