



TRANSFER NOTIFICATION

Physician Name:
Home Address:
Date of Birth:
Social Security #:
Phone:
Origin of Birth:
Case #:
Email Address:
Specialty

Former Employer:
Complete Address:
Phone:
Date of Transfer:
County:
HPSA ID:

New Employer:
Complete Address:
Phone:
HPSA ID:
County:

I certify that I, the undersigned, do provide primary health care services at the new location a minimum of 40 hours per week.

J-1 Physician's Signature Date

I do hereby certify that Dr. began practicing at on and provides primary health care services at the new HPSA location a minimum of 40 hours per week.

Facility Representative (Please Print) Title

Facility Representative's Signature Date

Subscribed and sworn to before me this day of, 20. Notary Public