APPLICATION FOR WAIVER OF THE TWO-YEAR FOREIGN RESIDENCE REQUIREMENT OF THE EXCHANGE VISITOR PROGRAM

SUPPLEMENTARY INFORMATION - B (Clinical Care)

The application form requests that certain supplementary information be provided with the application. Please follow the guidelines below.

Physician Requirements

(1) Department of State Data Sheet (2 copies).

(2) Readable copies of **J-1's** IAP-66 and/or DS 2019 forms for each year in J-1 status

(3) IMG Physician Statement [see 22 CRF Chap.1, Sec. 41.63(c)(4)(iii)]. MUST be in exactly this format:

> "I, (insert name of exchange visitor) hereby declare and certify, under penalty of the provisions of 10 U.S.C. 1001, that I do not now have pending nor am I submitting during the pendency of this request, another request to any United States Government department or agency or any State Department of Public Health, or equivalent, other than (insert name of U.S. Government Agency requesting waiver) to act on my behalf in any matter relating to a waiver of my two-year home-country physical presence requirement."

Statement must be signed by the physician and dated.

(4) Current CV, including Social Security number.

(5) Three letters of recommendation from those who know the J-1 physician's qualifications (these references must be current U.S. residents).

(6) Credentials (diplomas, licenses/license application).

(7) Completed J-1 Visa Waiver Applicant Credentials Verification Enrollment Data Sheet.

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Employer Requirements

(1) Completed HHS Application (Form HHS 426).

(2) Submitter's cover letter and G-28, if appropriate.

(3) A rural health clinic must submit a copy of the Centers for Medicare and Medicaid Services Letter of Certification.

(4) Letter of need from medical facility, on the facility's letterhead paper. Letter must include the identifier number of the federally-designated underserved area in which the facility is located. If the physician is to work at more than one site, identifier numbers for all sites must be included.

Also, the letter <u>must</u> include a statement that the facility:

- treats all patients regardless of their ability to pay,
- accepts Medicare, Medicaid, and S-CHIP assignment, and
- uses a sliding fee scale.

Letter must be signed by the head of the medical facility, and dated.

(5) Three letters of community support for the hire of this physician (must include contact information).

(6) State health department support/acknowledgment letter (if letter has not been received, enclose copy of facility's request for same—letter may be forwarded under separate cover when received).

(7) Department of State attestation [see 22 CRF Chap.1, Sec.41.63(c)(4)(ii)].

(8) Copy of executed contract. Contract must:

- be of three years' duration,
- obligate the physician to work 40 hours per week providing out-patient primary care (family practice, general internal medicine, general pediatrics, or obstetrics/gynecology) or general psychiatric services, and
- specify the site in which the physician will work (if more than one, all sites must be located in designated health professional shortage areas [HPSAs] with a score of 7 or higher, and HPSA identifier numbers must be provided).

NOTE: Contract <u>may not</u> contain a non-compete clause or restrictive covenant.

Contract must be signed by the head of the medical facility and the physician, dated, and notarized.

(9) Prevailing wage form.

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(10) Evidence of employer's regional and national recruitment efforts, including names of non-foreign physicians applying and/or interviewed, and reasons why they were not hired.

(11) Proof of facility's existence such as a phone book listing. (Further documentation may be required.)

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SUPPLEMENTARY INFORMATION - B (Clinical Care)

J-1 Visa Waiver Applicant Credentials Verification Enrollment Data Sheet

The Health Resources and Service Administration's J-1 Visa Waiver Service Unit is requesting verification of your credentials relative to your J-1 Visa waiver application. In order to provide you with an electronic credentials verification application, you MUST complete this document and submit it with the other required documentation. The credentials verification process will be initiated when a complete and acceptable application is received.

Please type or print clearly: *There may be instances when we have to contact you and it is important that your information is easily readable.*

Name:

____
First Name Last Name

SSN: ____ ____ ____ — ____ ____ — ____ ____ ____ ____

Gender: Male __ Female __ **Birth Date:**____ ____/____ ____/ ____ ____ ____ ____
MM DD YYYY

Preferred Address:

____ __________
Street Apt. #

________________________________ __________ __________
City State Zip Code

____
Country

Phone: (____ ____ ____) ____ ____ ____ — ____ ____ ____ ____
Area Code Phone #

Email Address (**VERY IMPORTANT**): ________________________________