



## **Ohio Department of Health 2016 State 30 J-1 Visa Waiver Program Application Packet**

Please read the instructions below in applying to the Ohio State 30 J-1 Visa Waiver Program. Applications that are complete and submitted in the order prescribed will be reviewed before those that do not follow submission guidelines.

### **I. Notice of Intent to Apply:**

Please complete the form provided and submit as soon as possible. Notice of Intent to Apply

### **II. To begin the application process to the Ohio State 30 J-1 Visa Waiver Program:**

In order to apply for a J-1 visa waiver, the J-1 physician must first file for a case number with the U.S. Department of State (DOS). Filing for a case number with DOS requires completing and submitting the online data sheet (DS – 3035), along with the DOS processing fee of \$120.00. Please do not submit the processing fee to the Ohio Department of Health (ODH). The processing fee must be submitted directly to DOS. Upon submitting the DS – 3035 online, the J-1 physician's information is immediately downloaded into a barcode and a case number is issued. A copy of this barcode is required for application to the Ohio State 30 J-1 Visa Waiver Program.

### **III. Submitting an Ohio State 30 J-1 Visa Waiver Application:**

All documents must be submitted in one application packet. Mail the original application and fee to:

Ohio Department of Health  
Attn: The Revenue Room – 1<sup>st</sup> Floor  
P.O. Box 15278  
Columbus, Ohio 43215

Mail a copy of the application to:

Ohio Department of Health  
Primary Care Office  
Attn: J-1 Visa Waiver Program  
246 N. High Street, 7th Floor  
Columbus, Ohio 43215

Be sure to check all documents for accuracy and consistency before submission. Discrepancies will require clarification, which will result in a delay in processing the application. Please note: no information pertaining to the application status will be provided while the application is in review.

1. **Non-refundable application fee.** Please make checks payable to Treasurer, State of Ohio in the amount of \$3,571.00.
2. **2016 State 30 J-1 Visa Waiver Program Priorities Form.** This new form outlines program priorities and provides applicants with a more clear understanding of their selected priority category.
3. **2016 ODH State 30 J-1 Visa Waiver Program Application.** This fillable form must be typed.
4. **Sliding Fee Scale (SFS)** based on 200% of the current federal poverty level, for the sponsoring organization and practice site, if different. The current federal poverty guidelines are available at <http://aspe.hhs.gov/poverty-research>. Also include a copy of the policy which explains the SFS implementation and the patient application for SFS services. **Hospital SFS information (both the SFS itself and the related policy) must clearly indicate that the SFS applies to physician services.** For more information about SFS, see the National Health Service Corps example at <http://nhsc.hrsa.gov/downloads/discountfeeschedule.pdf>.
5. **New practice site plan to achieve minimum SFS and Medicaid requirements** (if applicable). Note that new practice sites are allowable only for primary care physicians in Health Professional Shortage Areas (HPSAs).
6. **Non-Primary Care Supplement form** (if applicable):  
This form is to be completed if the J-1 physician candidate is a sub-specialist or is a primary care physician seeking to practice in a non-primary care position, e.g., as a Hospitalist or in Emergency Medicine. Please attach two letters from primary care providers outside of the sponsoring organization to document the practice site's collaboration with safety net providers in the service area. Letters from Federally Qualified Health Centers, Certified Rural Health Clinics, Free Clinics, Community Mental Health Agencies, and Patient-Centered Medical Homes are encouraged.
7. **Non-Primary Care Supplement for Public and Children's Hospitals on 2016 List form** (if applicable):  
This form is to be completed if the J-1 physician candidate is a sub-specialist or is a primary care physician seeking to practice in a non-primary care position, e.g., as a Hospitalist or in Emergency Medicine. Demonstration of contemporaneous training, recruitment or retention of a primary care physician is required for "regular" slot eligibility. If this requirement cannot be met, applicants may apply for a "flex" slot.
8. **Flex Slot Supplement form** (if applicable):  
This form is to be completed if the proposed practice site(s) is/are located outside of a HPSA or outside of an MUA/P on the 2016 list. The form should also be completed by public and children's hospitals on the 2016 list if they do not meet requirements for a "regular" slot, i.e. contemporaneous training, recruitment or retention of a primary care physician. **Note that ODH has the sole discretion to limit the number of waiver recommendations for sponsors who submit multiple applications.**
9. **Signed Public Notice Regarding Charges for Health Care Services form**, which must be prominently posted at each approved practice site.
10. **Evidence of J-1 physician applicant's Ohio medical license, or application for licensure with the State Medical Board of Ohio.** It is the responsibility of the applicant to assure that all materials for the physician licensure have been submitted to the State Medical Board of Ohio, and to forward notice of licensure upon receipt from Board.

Note that ODH will not finalize a waiver recommendation until a license is issued or until confirmation is received from the medical board that the only outstanding documentation required to issue a license is completion of the final year of the physician's training. If sponsor is an individual physician, please attach evidence of current, unrestricted Ohio medical license and provide assurance that sponsoring physician does not have a J-1 visa waiver obligation.

**11. Signed ODH State 30 J-1 Physician Applicant Agreement**, which includes agreement to complete a Verification of Employment Form and semi-annual patient activity reports.

**12. Copy of Data Sheet DS – 3035 and receipt of paid processing fee** (see II. above)

**13. Employment Agreement**, which must include:

- The complete address(es) of the practice location(s).
- A full-time, 40-hour work week in direct clinical care for three years (On-call and travel time is not counted in the required 40-hour work week).
- A statement documenting that the J-1 physician candidate agrees to begin work within 90 days of receipt of the J-1 waiver and the H1-B visa.
- A competitive salary for the area.
- The statement: "Any change or amendment to the employment contract must adhere to Ohio Department of Health (ODH) J-1 Visa Waiver requirements."
- Signature and date by both employer and physician.

Please note, the Employment Agreement cannot include:

- A non-compete clause.
- Termination without cause or by mutual agreement until the statutorily required three (3) years have expired.
- Allowance for changing or adding practice sites without prior approval from ODH and USCIS.
- In addition, only one employment agreement is permitted between the sponsor and the J-1 physician during the physician's 3-year obligation. Contracts that may be in place for physicians on O-1 visas prior to receipt of J-1 visa waiver approval must be terminated before the physician's J-1 visa waiver obligation start date.

**14. Signed Agreement to Contractual Requirements: Section 214 (1) of the Immigration and Nationality Act form**

**15. Signed Exchange Visitor Attestation form**

**16. All IAP – 66/DS – 2019 forms** (in chronological order with no time gaps)

**17. Sponsoring Organization's Letter to Richard Hodges, Director of Health**, which must:

- List the sponsoring organization, practice site (if different) and name and specialty of J-1 physician applicant.
- Define the service area for the sponsoring organization and practice site, if different.
- Provide site-specific staffing information, including total number of positions by specialty and number of vacancies.
- Describe how this request will address unmet need in the service area for the medical specialty of the J-1 physician applicant.
- Document that efforts to recruit a U.S. citizen physician for the same specialty and site have been conducted over the past twelve months and have been unsuccessful. A summary description is requested. Do not submit copies of ads, emails, recruitment firm contracts, etc.

**18. Evidence of Shortage Designation status** for placements in HPSAs and MUA/Ps on the 2016 list only. Please verify HPSA status at <http://hpsafind.hrsa.gov/> and submit a copy of the verification from the HRSA website. For MUA/Ps on the 2016 list, please verify MUA/P status at <http://muafind.hrsa.gov/> and submit a copy of the verification from the HRSA website.

**19. Personal Statement from J-1 Physician:**

The J-1 physician candidate must prepare a statement regarding his/her reasons for not wishing to fulfill the two-year home country residence requirement, which was agreed to at the time of acceptance of exchange visitor status.

**20. Curriculum Vitae of J-1 Physician**

**21. Notice of Entry of Appearance as Attorney or Representative, Form G-28** (if applicable)

**22. Copies of most recent I-94 DHS printout**

**23. A “No Objection” Statement from the visitor’s government** *if* foreign government funding is involved (if applicable)

**24. Checklist indicates that application has been thoroughly reviewed for accuracy and consistency.**

**IV. Recommendations by the Director of Health:**

Applications that receive a recommendation for approval by the Director of Health will be forwarded to the U.S. Department of State (DOS) for review, along with the cover letter from ODH. A copy of this cover letter will be sent to the sponsor-identified contact person for reference. Once the application has been approved by DOS, it is forwarded to USCIS. As the waiver-granting authority, USCIS will then issue the H-1B work visa for an approved application.

Applicants that are not recommended for approval will be sent formal notice from ODH. Applications are valid for the program year (federal fiscal year) only. For consideration in the following program year, a new application and accompanying fee must be submitted.



# Ohio Department of Health

## 2016 State 30 J-1 Visa Waiver Program Application

**PLEASE TYPE RESPONSES**

<b>I. <u>Sponsoring Organization Information</u></b>			
Sponsoring Organization Name: _____			
Address: _____			
City: _____	State: _____	Zip+4: _____	County: _____
Contact Person: _____		Title: _____	
Email: _____		Phone: _____	Fax: _____
<b>Type of Practice</b> <input type="checkbox"/> Federally Qualified Health Center <input type="checkbox"/> Certified Rural Health Clinic <input type="checkbox"/> Critical Access Hospital <input type="checkbox"/> Free Clinic <input type="checkbox"/> National Health Service Corps site		<b>Type of Organization</b> <input type="checkbox"/> For-Profit <input type="checkbox"/> Non-Profit <input type="checkbox"/> Public  <b>Number of Years in Operation</b> _____	
<input type="checkbox"/> Federally Qualified Health Center Look-Alike <input type="checkbox"/> Patient-Centered Medical Home <input type="checkbox"/> Community Mental Health Agency <input type="checkbox"/> State Agency _____ <input type="checkbox"/> Other (specify) _____			

<b>II. <u>Physician Information</u></b>			
Name, Last: _____	First: _____	Middle: _____	Phone: _____
Address: _____			Cell: _____
City: _____	State: _____	Zip+4: _____	E-mail: _____
Country of birth: _____		Country of last residence: _____	
<b>Physician Specialty</b> <i>(select all that apply)</i> <input type="checkbox"/> FP <input type="checkbox"/> IM <input type="checkbox"/> OB/GYN <input type="checkbox"/> PED <input type="checkbox"/> General Psychiatry <input type="checkbox"/> Geriatrics <input type="checkbox"/> IM/PED <input type="checkbox"/> Adolescent Medicine <input type="checkbox"/> Child/Adolescent Psychiatry <input type="checkbox"/> Geriatric Psychiatry <input type="checkbox"/> Other _____			Date of Birth: ____/____/____  Date Available: ____/____/____  National Provider Identifier (NPI): _____
<b>Languages Spoken</b> _____ _____ _____		<b>Race</b> <i>(select all that apply)</i> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Other _____	
<b>Ethnicity</b> <i>(select only one)</i> <input type="checkbox"/> Hispanic or Latino/a <input type="checkbox"/> Not Hispanic or Latino/a			

<b>Education</b>	
Medical School: _____	City/Country: _____
Dates of Attendance: ____/____/____ through ____/____/____	Graduation: ____/____/____
Residency Program: _____	City/State: _____
Dates of Attendance: ____/____/____ through ____/____/____	Graduation: ____/____/____
Additional Training: _____	City/State: _____
Dates of Attendance: ____/____/____ through ____/____/____	Completion: ____/____/____

<b>Current Visa Status</b> <i>(select one)</i> <input type="checkbox"/> J-1 <input type="checkbox"/> H-1B <input type="checkbox"/> O-1 <input type="checkbox"/> Out of Status (Note: not eligible) <input type="checkbox"/> Other: _____
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<b>Credentials</b> List state(s) of current licensure. If not currently licensed in Ohio, list date of application. _____ Note any licensure restrictions: _____
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**III. Practice Site Information** *If more than one practice site is proposed, please copy and complete this form for each site.*

Practice Site Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4: \_\_\_\_\_ County: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Is the proposed practice site located in a Health Professional Shortage Area (HPSA) or Medically Underserved Area/Population (MUA/P) on the 2016 list? Yes  No

Is the proposed practice site an integrated care site? Yes  No

*Practice sites that provide integrated primary care and mental health services may use primary care and mental health HPSAs in determining the patient origin data. Integrated care sites include 1) primary care sites that offer mental health services on-site and 2) mental health sites that offer primary care services on-site.*

Please list name(s) and I.D. number(s) of HPSA(s) and MUA/Ps on the 2016 list where practice site is located and/or where patients originate from: \_\_\_\_\_

**Type of Practice**

- Federally Qualified Health Center
- Certified Rural Health Clinic
- Critical Access Hospital
- Free Clinic
- National Health Service Corps site
- Federally Qualified Health Center Look-Alike
- Patient-Centered Medical Home
- Community Mental Health Agency
- State Agency \_\_\_\_\_
- Other (specify) \_\_\_\_\_

**Type of Organization**

- For-Profit
- Non-Profit
- Public

**Number of Years in Operation**

\_\_\_\_\_

If more than one practice site is proposed, please list the hours per week the physician will see patients at each practice address.

<u>Site Name / Address</u>	<u>Hours</u>
_____	_____/wk.
_____	_____/wk.

Does the practice participate in the Ohio Medicaid program? Yes  No

Does the practice accept new Medicaid patients? Yes  No

Does the practice accept assignment in the Medicare program? Yes  No

Does the practice provide services regardless of the patients' ability to pay? Yes  No

Does the practice use a **current** sliding fee scale for patients with incomes at/below 200% of the Federal Poverty Guidelines? *Please attach sliding fee scale and policy.* Yes  No

**Practice Site Payer Mix Data:** *Provide actual numbers for the most recent 12-month period and specify the time period. For a new practice site located in a HPSA for which 12-month payer mix data is not available, data for a comparable site may be submitted. If using data for a comparable site, please complete the table below and attach a written plan to achieve the minimum percentages at the new site. Please be sure to identify the comparable site in the written plan.*

**Time period:** \_\_\_\_\_

Payer	Number of Unduplicated Patients	Percentage of Total Patients	<div style="border: 1px solid black; width: 100px; height: 100px; margin: 0 auto;"></div> <p><i>Total percentage for Medicaid and Sliding Fee Scale must be equal to or greater than 30%.</i></p>
Medicaid			
Sliding Fee Scale			
Medicare			
Private Insurance			
No Charge or No Payment by Client			
Other (specify) _____			
<b>Total</b>			

**IV. Attorney Information** (if applicable)

Name, Last:

First:

Middle:

Name of Firm:

Address:

City:

State:

Zip+4:

Email:

Phone:

Fax:

**V. Sponsor-Identified Representative** Please identify one contact person who will be responsible for all correspondence on this application. The contact person may be an employee of the sponsoring organization, its legal representative or the physician applicant. **Sponsors submitting multiple applications in a program year must identify the same representative for all applications. Applications that do not follow this requirement will not be reviewed until a common site-identified representative is named.**

Contact Name:

Title:

Name of Organization:

Address:

City:

State:

Zip+4:

Email:

Phone:

Fax:

**VI. Sponsoring Organization Assurances**

My signature below is assurance that this application contains true and correct information and that the site will be in compliance with all Ohio and Federal visa waiver requirements as long as any physician obligated to fulfill his or her visa waiver commitment at the site.

Print Name and Title of Sponsoring Organization Official:

\_\_\_\_\_

Signature of Sponsoring Organization Official:

\_\_\_\_\_ Date: \_\_\_\_\_

**VII. Physician Assurance**

My signature below is assurance that the *Physician Information* section of this application contains true and correct information.

Print Name of Physician:

\_\_\_\_\_

Signature of Physician:

\_\_\_\_\_ Date: \_\_\_\_\_



## 2016 State 30 J-1 Visa Waiver Program Priorities Form

The Ohio J-1 Visa Waiver Program maintains a preference for primary care physicians who will practice in HPSAs. Applications are prioritized in the order listed below. Note that ODH has the sole discretion to limit the number of waiver recommendations for sponsors who submit multiple applications.

**Please check the appropriate program priority for this application. Choose only one category. Applications for multiple practice sites will be considered only for a “flex” slot if any one of the sites is classified as a “flex” slot.**

1. **Primary Care** - Includes physicians who complete post-graduate training in the specialties of Family Practice, General Internal Medicine, Obstetrics/Gynecology, General Pediatrics, Combined Internal Medicine/Pediatrics, Adolescent Medicine or Geriatrics and will be practicing primary care. Physicians who complete post-graduate training in General Psychiatry, Child/Adolescent or Geriatric Psychiatry are considered as primary care placements in mental health HPSAs.
  - Primary care specialties in primary care HPSAs and psychiatry specialties in mental health HPSAs.
  - Primary care specialties in MUA/Ps on current year’s lists (Eligible Public and Children’s Hospitals in MUAs and Eligible MUA/Ps).
  - All other primary care placements - “flex” slots.
  
2. **Non-Primary Care** - Includes all specialties not identified in 1 above and primary care physicians who will be practicing in an inpatient setting, including Hospitalists and Emergency Medicine.
  - Non-primary care specialties in primary care HPSAs and psychiatry subspecialties in mental health HPSAs.
  - Non-primary care specialties in eligible public and children’s hospitals in MUAs on current year’s list.
  - Non-primary care specialties in all other MUA/Ps on current year’s list.
  - All other non-primary care placements - “flex” slots.

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Sponsor Name



## Non-Primary Care Supplement

This form is to be completed by the sponsoring organization if the J-1 candidate is a non-primary care physician. Primary care specialties include Family Practice, General Internal Medicine, Obstetrics/Gynecology, General Pediatrics, Combined Internal Medicine/Pediatrics, and General Psychiatry. Primary care physicians who have completed fellowship training in Geriatrics, Adolescent Medicine, Child/Adolescent Psychiatry or Geriatric Psychiatry also meet the definition of primary care for purposes of the Ohio State 30 J-1 Visa Waiver Program. **Applications for primary care physicians who will be practicing in an inpatient setting, including Hospitalists or Emergency Medicine, are considered non-primary care applications and must complete this form.**

**1. Please define the service area for this placement and explain how this physician will fill an unmet need for the specialty within this service area. Include the recommended population-to-physician ratio for the specialty from recognized professional association sources in comparison to the current ratio for the service area. Also include other factors that impact patient access to care, e.g. patient travel time or appointment wait time. Please do not submit copies of journal articles, although citations are encouraged.**

**2. Please attach two letters from primary care providers outside of the sponsoring organization to document the practice site's collaboration with safety net providers in the service area. Letters from Federally Qualified Health Centers, Certified Rural Health Clinics, Free Clinics, Community Mental Health Agencies, and Patient-Centered Medical Homes are encouraged.**



## **Non-Primary Care Supplement for Public and Children's Hospitals on 2016 List**

Public and children's hospitals on the 2016 list may apply for "regular" slots for non-primary care placements in their facilities by demonstrating contemporaneous training, recruitment or retention of a primary care physician for an Ohio Health Professional Shortage Area (HPSA) or safety net site, i.e. a site having a payer mix of 30% or more Medicaid and/or sliding fee scale patients.

Public and children's hospitals on the 2016 list that do not meet the above criteria will be considered for "flex" slots.

**Please check one of the following means by which your application meets the above requirement and attach relevant supporting documentation.**

- 1. Description of medical student or primary care resident training currently occurring in an Ohio HPSA or safety net site outside of the hospital system.
- 2. Proof of intended practice in an Ohio HPSA or safety net site outside of the hospital system by one or more 2016 primary care residency program graduates.
- 3. Documentation of specific assistance currently provided to facilitate retention of a primary care physician in an Ohio HPSA or safety net site outside of the hospital system.



**Flex Slot Supplement**

This form is to be completed by the sponsoring organization if the proposed practice site(s) is/are located outside of a Health Professional Shortage Area (HPSA) or a Medically Underserved Area/Population (MUA/P) on the 2016 list. Specifically, sites applying for primary care and other specialty/sub-specialty positions must complete this form if the practice site(s) is/are located outside of a Primary Care HPSA or an eligible MUA/P. Sites applying for psychiatric positions must complete this form if the practice site(s) is/are located outside of a Mental Health HPSA. **Note that ODH has the sole discretion to limit the number of waiver recommendations for sponsors who submit multiple applications.**

**1. Is this facility operated by a state agency?**  Yes  No

If yes, please check the agency below and stop (state agencies are deemed to meet program criteria).

- Ohio Department of Mental Health and Addiction Services
- Ohio Department of Youth Services
- Ohio Department of Rehabilitation and Correction
- Other \_\_\_\_\_

If no, please continue to question #2.

**2. Has this site been in operation for at least one year at time of application?**  Yes  No

If yes, please provide the date that the site became operational: \_\_\_\_\_  
(and continue to question #3) mm/dd/yyyy

If no, stop. Please note that eligible sites for flex slots are required to be in operation for at least one year at time of application.

**3. Does this site's<sup>1</sup> patient origin data document service to residents of HPSAs, MUA/Ps on the 2016 list and/or Governor's Certified Shortage Areas?**

Yes  No

If yes, check which criteria are met.

- A minimum of 30% of the site's patients have originated from one or more HPSAs, MUA/Ps on the 2016 list and/or Governor's Certified Shortage Areas.
- A minimum of 20% of the site's patients have originated from one or more HPSAs, MUA/Ps on the 2016 list and/or Governor's Certified Shortage Areas **and** there are no geographic, socio-economic or cultural barriers for these patients in accessing care at this site.

If no, stop. Please note that sites eligible for flex slots are required to meet one of the above.

\_\_\_\_\_  
*Name of Practice Site*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Site Official*

\_\_\_\_\_  
*Printed Name and Title of Site Official*

<sup>1</sup> Practice sites that provide integrated primary care and mental health services may use primary care and mental health HPSAs in determining the patient origin data. Integrated care sites include 1) primary care sites that offer mental health services on-site and 2) mental health sites that offer primary care services on-site.



**PUBLIC NOTICE REGARDING CHARGES FOR  
HEALTH CARE SERVICES**

**This practice has adopted the following policies, which apply to all physicians at this site.**

- We will charge persons receiving health care services at no more than the usual and customary rate prevailing in this area. Health services will be provided at no charge, or at a reduced charge, to persons unable to pay for services according to a posted sliding fee scale.
- We will charge for services to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges.
- We will not discriminate against any person receiving health services because of his/her inability to pay for services, or because payment for the health services will be made under the Medicare or the Medicaid programs.
- We will accept assignment for all services for which payment may be made under the Medicare program. We have entered into an appropriate agreement with the Ohio Department of Medicaid and will provide services to Medicaid-covered individuals.

\_\_\_\_\_  
*Name of Sponsoring Organization*

\_\_\_\_\_  
*Signature of Sponsoring Organization Official*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name and Title of Sponsoring Organization Official*

***If the practice site is different than the sponsoring organization listed above, please complete the following section.***

\_\_\_\_\_  
*Name of Site*

\_\_\_\_\_  
*Signature of Site Official*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name and Title of Site Official*

**This notice is to be posted in a prominent location in the patient waiting area of each site that participates in the Ohio State 30 J-1 Visa Waiver Program.**



**Ohio Department of Health  
State 30 J-1 Visa Waiver Program  
Physician Applicant Agreement**

I, \_\_\_\_\_, M.D., being duly sworn, hereby request the Ohio State Health Officer, acting in his/her capacity as Director of ODH, to review my application for the purpose of recommending waiver of the foreign residency requirement set forth in my J-1 Visa, pursuant to the terms and conditions as follows:

I understand and acknowledge that the submission of a complete application to ODH does not ensure a favorable waiver recommendation. In the event a decision is made not to grant my request, I hold harmless ODH, the Director, and any and all ODH employees, agents and assigns from any action or lack of action made in connection with this request.

I further understand and acknowledge that the entire basis for the consideration of my request is ODH's voluntary policy and desire to improve the availability of primary medical care, mental health, and sub-specialty care in regions designated as underserved in Ohio.

I expressly understand that this waiver of my foreign residence requirement must ultimately be approved by the U.S. Citizenship and Immigration Services (USCIS). **I agree to provide ODH a completed Verification of Employment Form within 30 days of my waiver obligation employment start date.**

I understand that any recommendation made by ODH on my behalf is specific to the site(s) included in the letter of recommendation from ODH to the U.S. Department of State. Any change in site location must be pre-approved by ODH and USCIS.

I understand and acknowledge that if I willfully fail to comply with the terms of this agreement, ODH will notify USCIS and recommend deportation proceedings be instituted against me. Additionally, any and all other measures available to ODH will be taken in the event of my non-compliance. **Furthermore, I agree to submit semi-annual patient activity reports to ODH on the form supplied by ODH.**

I declare under the penalties of perjury that the foregoing is true and correct.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

Subscribed and sworn to before me

This \_\_\_\_\_ day of \_\_\_\_\_, 201\_\_.

Notary Public



**Agreement to Contractual Requirements of  
Section 214 (I) of the Immigration and Nationality Act**

This is to certify that I, \_\_\_\_\_, M.D.  
*(print or type name here)*

agree to comply with the contractual requirements set forth in Section 214 (1) of the Immigration and Nationality Act, as stated below:

a) The alien demonstrates a bona fide offer of "full-time" (40 hrs.) employment at a health facility and agrees to begin employment at such facility within 90 days of receiving such waiver and agrees to continue to work in accordance with paragraph (2) at the health care facility in which the alien is employed for a total of not less than three years (unless the Attorney General determines that extenuating circumstances such as the closure of the facility or hardship to the alien would justify a lesser period of time).

and

b) The alien agrees to practice medicine in accordance with paragraph (2) for a total of not less than three years only in the geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals, or in a facility that serves patients who reside in one or more geographic areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

Subscribed and sworn to before me

This \_\_\_\_\_ day of \_\_\_\_\_, 201\_\_.

Notary Public



**Exchange Visitor Attestation**

I, \_\_\_\_\_, M.D. hereby declare and certify, under penalty of the  
*(print or type name here)*

provisions of 8 USC 1101, that: (1) I have sought or obtained the cooperation of the **Ohio Department of Health** for the purpose of submitting an IGA request on my behalf under the Conrad 30 Program to obtain a waiver of the two-year home-country physical presence requirement; and (2) I do not now have pending nor will I submit another request to any U.S. Government department or agency or its equivalent, to act on my behalf in any matter relating to a waiver of my two-year home residence requirement.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

Subscribed and sworn to before me  
This \_\_\_\_\_ day of \_\_\_\_\_, 201\_\_.  
Notary Public



## Ohio Department of Health State 30 J-1 Visa Waiver Program Application Checklist

Please place documents in the following order and include the U.S. Department of State case number on the bottom right of each page. Applications that are complete and submitted in the order prescribed will be reviewed before those that do not follow submission guidelines. Original and one copy of the application are required.

1.	Application Fee (made out to Treasurer, State of Ohio): \$3,571.00
2.	U.S. DOS case number included on the bottom right of each page.
3.	2016 State 30 J-1 Visa Waiver Program Priorities Form
4.	Ohio Department of Health State 30 J-1 Visa Waiver Application
5.	Sliding Fee Scale (SFS) based on 200% of the <u>current</u> federal poverty level, for the sponsoring organization and practice site, if different. Also include a copy of the policy which explains the SFS implementation and patient application for SFS services.
6.	New practice site plan to achieve minimum SFS and Medicaid requirements ( <i>if applicable</i> )
7.	Non-Primary Care Supplement ( <i>if applicable</i> ) and at least two required letters of support from safety net providers outside of the sponsoring organization
8.	Non-Primary Care Supplement for Eligible Public and Children's Hospitals ( <i>if applicable</i> ) and demonstration of meeting requirement for primary care physician training, recruitment or retention.
9.	Flex Slot Supplement ( <i>if applicable</i> )
10.	Signed Public Notice Regarding Charges for Health Care Services form
11.	Evidence of J-1 physician applicant's Ohio medical license, or application for licensure with the State Medical Board of Ohio.
12.	Signed Ohio Department of Health State 30 J-1 Physician Applicant Agreement
13.	Copy of Data Sheet DS-3035 and receipt of paid processing fee
14.	<p>Employment Agreement, which must include:</p> <ul style="list-style-type: none"> <li>○ The complete address(es) of practice location(s)</li> <li>○ A statement documenting that the J-1 physician candidate agrees to begin to work within 90 days of receipt of the J-1 waiver and H1-B visa</li> <li>○ A full-time, 40-hour work week in direct clinical care for three years (On-call and travel time is not counted in the required 40-hour work week)</li> <li>○ A competitive salary for the area</li> <li>○ The statement: "Any change or amendment to the employment contract must adhere to Ohio Department of Health (ODH) J-1 Visa Waiver requirements."</li> <li>○ Signature and date by both employer and physician</li> </ul> <p>Please note, the employment agreement cannot include:</p> <ul style="list-style-type: none"> <li>○ A non-compete clause</li> <li>○ Termination without cause or by mutual agreement until the statutorily required three (3) years have expired.</li> <li>○ Allowance for changing or adding practice sites without prior approval from ODH and USCIS.</li> <li>○ In addition, only one employment agreement is permitted between the sponsor and the J-1 physician during the physician's 3-year obligation. Contracts that may be in place for physicians on O-1 visas prior to receipt of J-1 visa waiver approval must be terminated before the physician's J-1 visa waiver</li> </ul>
15.	Signed Agreement to Contractual Requirements: Section 214 (1) of the Immigration and Nationality Act
16.	Signed Exchange Visitor Attestation form
17.	All IAP-66/DS-2019 forms (in chronological order with no time gaps)
18.	Letter from Sponsoring Organization to Director of Health
19.	Evidence of Shortage Designation Status (for HPSA and eligible MUA/P placements only)



**Ohio Department of Health  
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20. Personal Statement from J-1 physician
21. Curriculum Vitae of J-1 physician
22. Notice of Entry of Appearance as Attorney or Representative, Form G-28 ( <i>if applicable</i> )
23. Copies of most recent I-94 DHS printout
24. No Objection Statement ( <i>if applicable</i> )
25. Checklist indicates that application has been thoroughly reviewed for accuracy and consistency