



Ohio Department of Health State 30 J-1 Visa Waiver 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.

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.

For more information on filing for a case number, please refer to the following website:
http://travel.state.gov/visa/temp/info/info_1296.html.

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 – 1st 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. **ODH State 30 J-1 Visa Waiver Application** (please refer to the definitions of practice site types document for completion of the application).
3. **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/14poverty.cfm>. Also include a copy of the policy which explains the SFS implementation. Hospital SFS information (both the SFS itself and the related policy) must clearly indicate that the SFS applies to physician services.
4. **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).
5. **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. At least two letters from primary care providers outside of the sponsoring organization are required to document the practice site's collaboration with primary care providers in the service area. Letters from Federally Qualified Health Centers, other safety net providers, and/or practices recognized as Patient-Centered Medical Homes are encouraged.
6. **Non-Primary Care Supplement for Public and Children's Hospitals on 2015 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.
7. **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 2015 list. The form should also be completed by public and children's hospitals on the 2015 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 employers who submit multiple applications.
8. **Signed Public Notice Regarding Charges for Health Care Services form**, which must be prominently posted at each approved practice site.
9. **Evidence of J-1 physician applicant's Ohio medical license, or application for licensure with the State Medical Board of Ohio.** 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. 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.

10. Signed ODH State 30 J-1 Physician Applicant Agreement, which includes agreement to provide written notification to ODH at the time of approval by USCIS (U.S. Citizenship and Immigration Services) and upon commencing work requirements in Ohio. The form also includes an agreement to complete semi-annual patient activity reports.

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

12. 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. The Employment Agreement may not be terminated 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.

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

14. Signed Exchange Visitor Attestation form

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

16. 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.

17. Evidence of Shortage Designation status for placements in HPSAs and MUA/Ps on the 2015 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 2015 list, please verify MUA/P status at <http://muafind.hrsa.gov/> and submit a copy of the verification from the HRSA website.

18. 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.

19. Curriculum Vitae of J-1 Physician

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

21. Copies of I-94 Entry and Departure Cards (front and back, with legible dates)

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

23. 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 on 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

State 30 J-1 Visa Waiver Application

I. Sponsoring Organization Information

Sponsoring Organization Name: _____

Address: _____

City: _____ State: _____ Zip+4: _____ County: _____

Contact Person: _____ Title: _____

Email: _____ Phone: _____ Fax: _____

| | |
|--|---|
| <p>Type of Practice <i>(see definitions)</i></p> <p><input type="checkbox"/> Federally Qualified Health Center <input type="checkbox"/> Federally Qualified Health Center Look-Alike</p> <p><input type="checkbox"/> Rural Health Clinic <input type="checkbox"/> Patient-Centered Medical Home</p> <p><input type="checkbox"/> Critical Access Hospital <input type="checkbox"/> Community Mental Health Agency</p> <p><input type="checkbox"/> Free Clinic <input type="checkbox"/> State Agency _____</p> <p><input type="checkbox"/> National Health Service Corps site <input type="checkbox"/> Other (specify) _____</p> | <p>Type of Organization</p> <p><input type="checkbox"/> For-Profit <input type="checkbox"/> Non-Profit <input type="checkbox"/> Public</p> <p>Number of Years in Operation</p> <p>_____</p> |
|--|---|

II. Physician Information

Name, Last: _____ First: _____ Middle: _____ Phone: _____

Address: _____ Cell: _____

City: _____ State: _____ Zip+4: _____ E-mail: _____

Country of birth: _____ Country of last residence: _____ Date of Birth: ___/___/___

Physician Specialty *(select all that apply)*

FP IM OB/GYN PED General Psychiatry Geriatrics

IM/PED Adolescent Medicine Child/Adolescent Psychiatry Geriatric Psychiatry

Other _____

Date Available: ___/___/___

National Provider Identifier (NPI): _____

| | | |
|---|---|--|
| <p>Languages Spoken</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>Race <i>(select all that apply)</i></p> <p><input type="checkbox"/> American Indian/Alaskan Native</p> <p><input type="checkbox"/> Pacific Islander/Native Hawaiian</p> <p><input type="checkbox"/> White <input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> Other _____</p> | <p>Ethnicity <i>(select only one)</i></p> <p><input type="checkbox"/> Hispanic or Latino/a</p> <p><input type="checkbox"/> Not Hispanic or Latino/a</p> |
|---|---|--|

Education

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: ___/___/___

Current Visa Status *(select one)*

J-1 H-1B O-1 Out of Status (Note: not eligible) Other: _____

Credentials

List state(s) of current licensure. If not currently licensed in Ohio, list date of application. _____

Note any licensure restrictions: _____

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 2015 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 2015 list where practice site is located and/or where patients originate from: _____

Type of Practice *(see definitions)*

- Federally Qualified Health Center
- 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.

| Site Name / Address | Hours |
|---------------------|------------|
| _____ | _____ /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? *If yes, please attach sliding fee scale and policy.* Yes No

Practice Site Payer Mix Data: *Provide actual numbers and calculate percentages 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 |
|-----------------------------------|---------------------------------|------------------------------|
| Medicaid | | |
| Sliding Fee Scale | | |
| Medicare | | |
| Private Insurance | | |
| No Charge or No Payment by Client | | |
| Other (specify) _____ | | |
| Total | | |

}

Total percentage for Medicaid and Sliding Fee Scale must be equal to or greater than 30%.

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.**

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: _____

Ohio State 30 J-1 Visa Waiver Program Practice Type Definitions

Community Mental Health Agency - Community mental health agency or facility means a community mental health agency or facility that has its community mental health services certified by the department of mental health under section 5119.611 of the Revised Code or by the department of job and family services.

Critical Access Hospital (CAH) – A non-profit facility that is (a) located in a State that has established with the Centers for Medicare and Medicaid Services (CMS) a Medicare rural hospital flexibility program; (b) designated by the State as a CAH; (c) certified by the CMS as a CAH; and (d) in compliance with all applicable CAH conditions of participation.

Federally-Qualified Health Centers (FQHC) – FQHCs include nonprofit entities that receive a grant (or funding from a grant) under Section 330 of the Public Health Service (PHS) Act (i.e., health centers).

FQHC Look-Alike – Health centers that have been identified by Health Resources and Services Administration (HRSA) and certified by the Centers for Medicare and Medicaid Services as meeting the definition of “health center” under Section 330 of the PHS Act, although they do not receive grant funding under Section 330.

Free Clinic – A medical facility offering community healthcare on a free or very low-cost basis. Care is generally provided in these clinics to persons who have lower or limited income and no health insurance, including persons who are not eligible for Medicaid or Medicare. Almost all free clinics provide care for acute, non-emergent conditions. Many also provide a full range of primary care services (including preventive care) and care for chronic conditions.

National Health Service Corps (NHSC) Site – A site that has requested and been granted approval as an NHSC site. In order for a site to be eligible for NHSC approval, it must: Be located in and providing service to a federally designated HPSA; Provide primary medical care, mental and behavioral health and/or dental services; Provide ambulatory services (no inpatient sites); Ensure access to ancillary, inpatient and specialty referrals; Charge fees for services consistent with prevailing rates in area; Discount or waive fees for individuals at or below 200% of the Federal poverty level; Accept assignment for Medicare beneficiaries; Enter into agreements with Medicaid and the Children’s Health Insurance Program (CHIP), as applicable; Not discriminate in the provision of services based on an individual’s inability to pay for services or the source of payment (Medicare/Medicaid/CHIP); Prominently post signage that no one will be denied access to services due to inability to pay; Agree not to reduce clinician’s salary due to NHSC support; Provide sound fiscal management; and Maintain a recruitment and retention plan, as well as a credentialing process, for clinicians. If the Site Application is approved, the community site becomes an NHSC-approved service site. All NHSC-approved service sites must continuously meet the above requirements.

Patient-Centered Medical Home (PCMH) - Practices that meet any of the following criteria will be considered PCMHs: practices established as PCMH Education Pilot sites under Ohio House Bill 198,

National Committee for Quality Assurance (NCQA) recognized PCMH practices, Accreditation Association for Ambulatory Health Care (AAAHC) recognized PCMH practices, URAC accredited practices, Joint Commission certified practices, and practices included in the Center for Medicare and Medicaid Innovation's Comprehensive Primary Care initiative (CPCi). The PCMH model of care is one that facilitates partnerships between individual patients and their personal healthcare providers and, when appropriate, the patient's family. Care is managed using modern tools such as registries, information technology, health information exchange and other means to assure that patients get the appropriate care when and where they need and want it in a culturally appropriate manner.

Rural Health Clinic (RHC) – A facility certified by the Centers for Medicare and Medicaid Services under section 1861(aa)(2) of the Social Security Act that receives special Medicare and Medicaid reimbursement. RHCs are located in a non-urbanized area with an insufficient number of health care practitioners and provide routine diagnostic and clinical laboratory services. RHCs have a nurse practitioner, a physician assistant, or a certified nurse midwife available to provide health care services not less than 50 percent of the time the clinic operates.

State Agency – An organized body, office, or agency established by the laws of the state for the exercise of any function of state government. Universities are not included in this definition.



Ohio State 30 J-1 Visa Waiver Program Non-Primary Care Supplement for Public and Children's Hospitals on 2015 List

Public and children's hospitals on the 2015 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 2015 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 primary care residency training currently occurring in an Ohio HPSA or safety net site outside of the hospital system.
- 2. Proof of signed contracts by one or more 2015 primary care residency program graduates to practice in an Ohio HPSA or safety net site outside of the hospital system.
- 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 2015 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 employers 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 Corrections
- 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's¹ patient origin data document service to residents of HPSAs, MUA/Ps on the 2015 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 2015 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 2015 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.

¹ 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 also indicate the below information.

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 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 written notification to ODH at the time I receive approval from USCIS and commence program work requirements in Ohio.**

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 _____, 200__.
Notary Public



**Agreement to Contractual Requirements of
Section 214 (1) 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 _____, 200__.

Notary Public



Exchange Visitor Attestation

I, _____, M.D. hereby declare and certify, under penalty of the
(print or type name here)
provisions of 18U.S.C.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 _____, 200__.
Notary Public



Ohio Department of Health

State 30 J-1 Visa Waiver 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. | Ohio Department of Health State 30 J-1 Visa Waiver Application |
| 3. | 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. |
| 4. | New practice site plan to achieve minimum SFS and Medicaid requirements (<i>if applicable</i>) |
| 5. | Non-Primary Care Supplement (<i>if applicable</i>) and at least two required letters of support from primary care providers outside of the sponsoring organization |
| 6. | 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 and retention. |
| 7. | Flex Slot Supplement (<i>if applicable</i>) |
| 8. | Signed Public Notice Regarding Charges for Health Care Services form |
| 9. | Evidence of J-1 physician applicant’s Ohio medical license, or application for licensure with the State Medical Board of Ohio. |
| 10. | Signed Ohio Department of Health State 30 J-1 Physician Applicant Agreement |
| 11. | Copy of Data Sheet DS-3035 and receipt of paid processing fee |
| 12. | <p>Employment Agreement, which must include:</p> <ul style="list-style-type: none"> ○ The complete address(es) of practice location(s) ○ A statement documenting that the J-1 physician candidate agrees to begin to work in 90 days of receipt of the J-1 waiver and H1-B visa ○ 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 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 <p>Please note, the employment agreement cannot include:</p> <ul style="list-style-type: none"> ○ A non-compete clause ○ Termination without cause. The Employment Agreement may not be terminated 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. |
| 13. | Signed Agreement Contractual Requirements: Section 214 (1) of the Immigration and Nationality Act |
| 14. | Signed Exchange Visitor Attestation form |
| 15. | All IAP-66/DS-2019 forms (in chronological order with no time gaps) |
| 16. | Letter from Sponsoring Organization to Director of Health |
| 17. | Evidence of Shortage Designation Status (for HPSA and eligible MUA/P placements only) |

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| 18. | Personal Statement from J-1 physician |
| 19. | Curriculum Vitae of J-1 physician |
| 20. | Notice of Entry of Appearance as Attorney or Representative, Form G-28 (<i>if applicable</i>) |
| 21. | Copies of I-94 Entry and Departure Cards (front and back, with legible dates) |
| 22. | No Objection Statement (<i>if applicable</i>) |
| 23. | Checklist indicates that application has been thoroughly reviewed for accuracy and consistency |