Application for Washington State J-1 Physician Visa Waiver Program

Please type or print clearly and read all instructions carefully. Complete all sections of this application and attach required documentation in the requested order. Incomplete applications will be returned. Please refer to Chapter 246-562 WAC for additional information. The Department of Health (department) suggests, but it is not required, the applicant work with an immigration attorney to ensure all steps are in place that will allow the physician to work in the United States.

If you have questions concerning this application, please contact the department's Office of Community Health Systems.

Application instructions

- All documentation must have the U.S. Department of State Case Number on the bottom right hand corner of each page.
- Please use a single fastener to hold together the pages of the application. Do not use staples or paperclips to attach documents together.
- Order the two application packages in the following manner:

Main application package

1. Washington State J-1 Physician Visa Waiver Application
2. U.S. Department of State Data Sheet (DS-3035)
3. Employment contract
4. Physician attestation that no other waiver application is pending
5. All U.S. Department of State DS-2019 forms (Certificate of Exchange visitor status)
6. Letter from applicant requesting waiver sponsorship
7. Evidence of Health Professional Shortage Area (HPSA) designation status (if applicable)
8. Physician statement describing reason for not wishing to fulfill the two year home country residency requirement
9. Current curriculum vitae for the physician
10. An explanation for any time out of J-1 status (if applicable)
11. USCIS G-28 Notice of Entry of Appearance from attorney (if applicable)
12. USCIS I-94 entry and departure cards
13. Copy of "No Objection" letter or a signed statement that a "No Objection" letter is not required
14. Supporting documents from applicant:
    a. Sliding fee discount schedule, policy, and photograph of posted notice in patient waiting area
    b. Supporting documentation for a new practice location (if applicable, see question 5)
    c. Single example from recruitment effort (see question 11)
15. Supporting documentation from physician:
    a. Evidence of current status as medical resident or completion of medical residency program

b. ONLY if physician does not yet have an active license under chapter 18.71 or 18.57 RCW, a copy of medical degree with certified translation if necessary and proof of passage of examination

16. Specialty Waiver Addendum and supporting documentation (if applicable)
17. Non-HPSA Waiver Addendum and supporting documentation (if applicable)

Secondary application package, only include the documents listed below.

1. U.S. Department of State Data Sheet
2. Employment contract
3. Physician attestation that no other waiver application is pending
4. All U.S. Department of State DS-2019 forms (Certificate of Exchange visitor status)
5. Letter from applicant requesting waiver sponsorship
6. Evidence of HPSA designation status (if applicable)
7. Physician statement describing reason for not wishing to fulfill the two year home country residency requirement
8. Current curriculum vitae for the physician
9. An explanation for any time out of J-1status (if applicable)
10. USCIS G-28 Notice of Entry of Appearance from attorney (if applicable)
11. USCIS I-94 entry and departure cards
12. Copy of "No Objection" letter or a signed statement that a "No Objection" letter is not required

All applications must be received by U.S. postal mail, commercial mail carrier, or be hand delivered.

Address for commercial mail carrier or hand delivery:

Washington State Department of Health
Office of Community Health Systems
Attention: J-1 Visa Waiver Program
111 Israel Road SE
Tumwater, WA 98501

Address for U.S. Postal Service:

Washington State Department of Health
Office of Community Health Systems
Attention: J-1 Visa Waiver Program
PO Box 47853
Olympia, WA 98504-7853

Applications will be accepted beginning October 1 of each federal fiscal year until all sponsorships have been filled. Applications received after all slots have been filled for the year will be returned to the applicant and may be resubmitted during the next application cycle.

The applicant will be notified in writing of the department's decision. If approved, the department will add the necessary documentation that indicates our intention to act as a sponsor and will forward the secondary application package to the U.S. Department of State. You will be notified by the U.S. Department of State of their approval or denial. The department's approval does not guarantee approval from the U.S. Department of State or the U.S. Citizenship and Immigration Services.

For DOH Office use only		Date received
Date approved:	Reviewed by:	
Application #	Waiver #	

Application for Washington State J-1 Physician Visa Waiver Program

U.S. Department of State Case Number:
(This number must be obtained prior to submitting application)

☐ Primary Care Application

☐ HPSA waiver

☐ Specialist Application (also complete Specialist Addendum and include with this application)

☐ Non-HPSA waiver (also complete Non-HPSA Addendum and include with this application)

Applicant information (The employer is the applicant)			
Name of applicant:			
Mailing address:			
City:		State:	Zip:
Contact during application process:		Phone:	
Washington State Business License Number (UBI#):		Email:	
Contact for reports and issues following waiver approval, if different than above:		Phone:	
		Email:	

Immigration attorney information (if applicable)			
Name:		Email:	
Mailing address:			
City:	State:	Zip:	Phone:

J-1 physician information		
Name:	Email:	Phone:
Home country:	WA State Medical License #	Date of birth:

Proposed practice location(s) for J-1 physician (Attach a list of additional practice locations if necessary)			
Practice street address:			
City:	State:	Zip:	HPSA ID:
Additional address:			
City:	State	Zip:	HPSA ID:

1. Nature of the services to be provided full time by the physician.

☐ Family Medicine ☐ General Internal Medicine ☐ Pediatrics
☐ Obstetrics and Gynecology ☐ Psychiatry ☐ Geriatric Medicine
☐ Hospitalist (Specialty in which the physician is board eligible or board certified):
☐ Specialist* (Identify type of specialty service):
***Specialists only: Please complete the Specialist Addendum**

2. Is the practice location in one of the following areas? (Check all that apply.)

☐ Geographic Health Professional Shortage Area (HPSA) ID#
☐ Population HPSA (Please specify the population): ID#
☐ Mental Health HPSA (For psychiatrists) ID#
☐ Facility Designation HPSA (e.g. FQHCs, Correctional Facilities) ID#
☐ Non-HPSA (Please complete the Non-HPSA Addendum)

Documentation Required: Provide the HPSA identifier of the designation unless seeking a non-HPSA designated area waiver. Physicians must work full time in a federally designated HPSA. Psychiatrists must work full time in a MHPSA. Designations change periodically. Current information about HPSA designations can be found online. HPSA designation identifiers are assigned by the U.S. Department of Health and Human Services.

3. Have you included a letter from the applicant requesting the department recommend a waiver?
☐Yes ☐No

Documentation Required: Provide a letter printed on the applicant's letterhead and signed by the head of the employing organization that: Identifies the physician by name; requests that the Washington State Department of Health act as an interested government agency and recommend a waiver for the J-1 physician; includes the complete address where physician will practice if the waiver is granted (county, street address, city and zip code, and HPSA identifier); summarizes how the applicant has attempted to locate qualified U.S. physicians; describes the physician's qualifications, proposed responsibilities and how the physician's employment will satisfy important unmet health care needs in the designated HPSA or the needs of individuals living in HPSA areas; and states unequivocally that the facility is offering the physician at least three years of employment.

4. Has the applicant provided healthcare services in Washington State for at least 12 months prior to submitting this visa waiver application? ☐Yes ☐No

Note: The applicant must have provided healthcare services in Washington for a period of 12 months prior to submitting this application.

5. Has the applicant provided healthcare services at the proposed practice location for at least 12 months prior to submitting this visa waiver application? ☐Yes ☐No

Documentation Required: For new practice locations only, provide documentation of legal, financial and organizational structure necessary to provide a stable full time practice environment. A business plan must be submitted that supports this information. Facilities must also explain how patients seen at this service site will be connected with other healthcare if needed.

6. Does the applicant have an existing sliding fee discount schedule that is updated to reflect the most recent federal poverty guidelines? ☐Yes ☐No

If no, does the applicant agree to implement a sliding fee discount schedule? ☐Yes ☐No

Documentation Required: Submit copies of the applicant's sliding fee discount schedule and policy. Sample schedules and notices are available from the department.

7. Does the practice location have a prominently posted notice for patients that states discounts are available? ☐Yes ☐No

Documentation Required: Submit a photograph of the posted notice. Notices must be in the primary language of the underserved population.

8. Which of the following new patient payer types is the applicant accepting? Please check all that apply.

☐ Medicare
☐ Medicaid (including both fee-for-service and managed care)
☐ Medicare/Medicaid dually eligible
☐ Uninsured patients with a sliding fee discount schedule

If not currently accepting new patients with the payment types listed above, which ones, why, and when does the practice plan to again accept new patients with that payer type?

9. During the 12 months preceding this application, did visits by Medicaid clients, Medicare/Medicaid dual eligible clients, and uninsured patients seen using a sliding fee discount scale make up at least 15 percent of the proposed practice location(s) visits? ☐Yes ☐No

Documentation Required: Please provide the following information for the proposed practice site(s) for the 12 month period preceding this application. Attach more sheets if needed.

Note: A minimum of 15 percent of the practice location's total patient visits must serve Medicaid clients, Medicare clients with Medicaid as secondary insurance and low-income individuals served via the sliding fee schedule. If the proposed practice location has not been operating 12 months then patient visit information for the applicant's existing facilities may be used.

12 month reporting period:	Total annual patients:	
Patient visits by primary insurance type		
Primary insurance	**Number of patient visits**	**Percentage**
Medicare without Medicaid secondary		
Medicare with Medicaid secondary (dual eligible)		
Medicaid (managed and fee for service)		
Other public insurance (e.g. L&I, county indigent care program)		
Private insurance		
Self-pay with sliding fee schedule discount		
Self-pay (no insurance and not on sliding fee schedule)		
Total		

10. Is the Physician complete with residency or fellowship training? ☐ Yes ☐ No

If no, provide the date physician will complete training:

Documentation Required: Submit a letter from the physician's residency or fellowship program that identifies the date the physician will complete their residency or fellowship program and confirms that the physician is in good standing with the program. The letter must be on the program's letterhead and provide contact information for the signatory; including name, title, relationship to the physician, address, and telephone number. If physician has completed the program please submit a copy of the graduate medical education diploma in place of a letter.

11. Did you actively recruit for a U.S. citizen or permanent resident physician candidate for at least six months before signing a contract with the J-1 physician? ☐ Yes ☐ No

Documentation Required: Provide the information requested below about the recruitment process for a U.S. candidate undertaken before the organization contracted with the J-1 physician. Please include with this application an example recruitment document to support the information below. This example document could be a listing in a national publication, web-based advertising or search agreement with a recruiter or recruitment firm.

Active recruitment period:	Date contract signed with J-1 visa waiver physician:

Recruitment efforts (Complete sections that apply, leave blank methods not used in the candidate search)	
Online advertisements	**Time period posted** (e.g. 12/15/2016-08/15/2016)
National publication advertisements	**Months published** (e.g. January, March 2016)
Contractual agreement with recruiter or recruitment firm (name of entity)	**Date firm began search**

Please describe any recruitment efforts in addition to those listed above, attach additional sheet if needed:

12. Do you have a signed employment contract with the physician that includes all the information described below? ☐Yes ☐No

Documentation Required: Provide two copies of the contract as directed by the instructions of this application. The contract must contain all the information and conditions outlined below:

- Name and address of the applicant who will be employing the physician
- Name and street address of the physician's proposed practice location(s)
- Statement of the specific HPSA(s) that will be served by the physician for the duration of the contract

- A service requirement of not fewer than three years from employment start date
- Statement that the physician will work not fewer than 40 hours per week providing direct clinical patient services in the HPSA or, in the case of a practice location without a HPSA designation, to residents of HPSAs
- Statement that the physician will begin employment within 90 days from the date of the granted waiver
- Identification of the wages to be paid to the physician
- Description of the physician's duties
- Description of the working conditions of the practice opportunity, including the facilities provided, malpractice insurance coverage, leave benefits, opportunities for continuing medical education, and other employee benefits
- Statement that the physician will provide physician services to Medicare recipients, Medicaid recipients, other low-income patients, and uninsured patients
- Statement that the physician must see all patients, regardless of ability to pay, based on a sliding fee discount schedule implemented by the applicant
- Statement that the applicant cannot prevent the physician from providing clinical patient services in the designated shortage area after the term of employment
- Statement by the physician that he or she agrees to meet the requirements set forth in Section 214(l) of the Immigration and Nationality Act

13. Does the contract include any handwritten notes or changes? ☐Yes ☐No

Documentation Required: All handwritten changes, notes or comments to the contract must be initialed and dated by both the physician as well as the person authorized by the applicant to sign the contract. Each copy of the contract must contain initials and dates.

14. Is the applicant offering the physician named in the visa waiver application the same working conditions and salary that it would have otherwise offered to a physician who graduated from a U.S. medical school? ☐Yes ☐No

Documentation Required: The working conditions and salary must be outlined in the employment contract between the applicant and the physician.

Proposed schedule for physician			
Weekday	**Work hours**	**Location**	**Total hours**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
Proposed call schedule:			

15. Does the applicant agree to notify the Department of Health in the event of any change in the physician's employment status, employment contract or a change in the ownership of the applicant or practice location if such occurs within the first three years from the state date of physician's employment? ☐**Yes** ☐**No**

Documentation Required: No additional documentation is required to accompany this application. Changes to the state or federal requirement of the employment contract must be submitted to the department for review and approval prior to implementation. The department will review and notify applicant of determination within 30 days of receipt of changes. Any changes in employment status may jeopardize the visa status of the physician. Failure to notify the department of any changes may result in notification of non-compliance to the U.S. Department of State, U.S. Citizenship and Immigration Services or U.S. Department of Labor as well as jeopardize the applicant's future participation in the Washington State J-1 Visa Waiver Program.

16. Does the physician have another application pending with any U.S. government or agency or any other State Department of Health to act on the physician's behalf in any matter relating to a waiver of the two-year home country physical presence requirement? ☐**Yes** ☐**No**

Documentation Required: Provide physician statement attesting that no other applications are pending. The federal government will not allow multiple J-1 visa waiver applications to be submitted simultaneously on behalf of the same physician.

17. Is the physician contractually obligated to return to a home country? ☐**Yes** ☐**No**

Documentation Required: If yes, then the physician must obtain a "No Objection" letter from the physician's home country and it must be mailed directly to the U.S. Department of State. Please include a copy with this application. OR If no, then a signed statement from the physician, indicating that a "No Objection" letter is not required because the physician is not contractually obligated to return to the home country must be included with this application.

18. Does the applicant agree to notify the Department of Health, in writing, of the start date of employment? ☐**Yes** ☐**No**

Note: The applicant must notify the department of the employment start date of the physician named in this application. The start date will be used to determine the due dates for the annual status reports.

19. Do the applicant and physician agree to provide required annual status reports to the department for a period of three years from the start date of employment? ☐**Yes** ☐**No**

Note: The reporting form is available from the department's Office of Community Health Systems. Employer report forms must be completed and signed by both the applicant and physician and submitted to the department within 30 days following the end of each annual period as established by the initial date of employment. If the applicant does not submit the required employer reports the department will find the applicant is in non-compliance and may notify U.S. Department of State and USCIS. Non-compliance may jeopardize the physician's visa status and the applicant's future participation in the J-1 Visa Waiver Program.

20. Does the physician agree to provide required annual retention reports to the department for a period of four years from the start date of employment? ☐**Yes** ☐**No**

Note: The reporting form is available from the department. The physician retention forms must be completed by the physician and submitted to the department within 30 days following the end of each annual period as established by the initial date of employment. If the physician does not submit the required retention forms the department will find the physician is in non-compliance and may notify U.S. Department of State and USCIS. Non-compliance may jeopardize the physician's visa status.

21. Does the applicant agree to cooperate in providing the department with clarifying information or information to verify the contents of this application or any investigation of the applicant's financial status?
☐Yes ☐No

Note: The applicant will be notified by the department if additional information or assistance is needed.

I hereby acknowledge that all information and statements contained herein are true and do not misrepresent fact. I further acknowledge that I have not evaded or suppressed any information contained in this application or in any of the supporting materials.

Applicant Signature	Date

Physician Signature	Date