State of Illinois
Illinois Department of Public Health

State 30 J-1
Visa Waiver Program

Revised August 2013

STATE OF ILLINOIS
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
J-1 VISA WAIVER PROGRAM

Overview

Below is the Illinois Department of Public Health's (Department) application process for the J-1 Visa Waiver Program. The Department's policies are also at 77 Ill. Adm. Code 591 (http://www.ilga.gov/commission/jcar/admincode/077/07700591sections.html). International medical graduates are hereinafter referred to as applicants.

Purpose, Authority and Scope

Section 220 of the Immigration and Nationality Technical Corrections Act of 1994 (P.L. 103-416), amended the provision of the Immigration and Nationality Act (act) regarding the two-year foreign residence requirement affecting applicants. These applicants were admitted to the United States on a J visa, or acquired such status after admission to the United States, and must return to the country of their nationality or last residence upon the completion of their participation in an exchange visitor program.

The Bureau of Citizenship and Immigration Services may grant a waiver of the two-year home country physical presence requirement upon the recommendation of the director of the United States Department of State, Waiver Review Division. The act authorizes the Department to request the director of the U.S. Department of State, Waiver Review Division, recommend that the Bureau of Citizenship and Immigration Services grant the waiver.

The applicant must demonstrate that he/she has a bona fide offer of full-time employment, that he/she will begin employment within 90 days of receiving a waiver and that he/she will continue to work for a total of not less than three years at a health care facility in an area designated by the U.S. Secretary of Health and Human Services as having a shortage of health care professionals.

Under the amendment to section 212(e) of the act, the commissioner of the Immigration and Naturalization Service will look to the director of the United States Department of State, Waiver Review Division, for a recommendation on applicant waiver cases brought "pursuant to the request of a state department of public health or its equivalent."

Under Section 214(k)(1)(A), the U.S. Attorney General will not grant the waiver unless the country to which the applicant is contractually obligated to return furnishes the director of the U.S. Department of State, Waiver Review Division, with a written statement that it has no objection to such waiver. State departments of health are allowed to request applicants sign a certification statement indicating presence or absence of a contractual obligation to their home country or country of last residence. Only in instances where such a contractual obligation exists will the physician be required to obtain a letter of no objection.

Eligible Physicians

The Illinois J-1 Visa Waiver Program accepts applications from all medical specialties based on the selection allocation outlined on Page 6.

Eligible Practice Opportunities

Federal regulations require the applicant to be employed by a "facility" as defined at 42 CFR 5.2, Designation of Health Professional Shortage Areas. A copy of that information is included with this material.

The regulations also require the applicant to be employed within a federally designated health professional shortage area (HPSA), a medically underserved area (MUA) or with a medically underserved population (MUP), or if not located in a HPSA or MUA/P, documentation that at least 51 percent of the applicants' patients will come from a HPSA or MUA/P. If an applicant will be employed in an area having a population group designation, the facility will be required to demonstrate in the application how it plans to reach the underserved population group. There must be a semi-annual documentation that at least 51 percent of the patients served by the applicant come from the underserved population group or area(s).

Application Processing Fee

The U.S. Department of State, Waiver Review Division, requires a user fee to cover costs of processing the two-year home residence waiver application. **DO NOT** send a check with your initial application to the Department. When all applications sent to the Department have been reviewed and decisions made, those applicants whose requests will be forwarded to the U.S. Department of State, Waiver Review Division, will be contacted and asked to forward a check to that agency.

Application Package

The application shall include the following:

1. Copy of U.S. Department of State, J-1 Visa Waiver Recommendation Application (DS-3035).

2. Copy of a minimum three-year employment contract between the applicant and a health care facility that includes the name and address of the facility, identifies the specific geographic area(s) in which the applicant will practice, and specifies that the physician will practice full time and will practice only in the specified geographic area identified in the contract.

3. DS-2019/IAP-66 (Certificate of Eligibility for Exchange Visitor J-1 Status) for each year applicant was in J-1 status.

4. Statement from the director of the health care facility or agency that will employ the applicant which describes the:

   a. Prior recruitment difficulties experienced by the facility or agency;
   b. Expected practice arrangement for the applicant; and
   c. Impact on the facility or agency and the patients it serves if the waiver is not granted.

5. Proof that the health care facility is located in a shortage area. Printout with HPSA data available at http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx

6. Personal statement from the applicant on reasons for not wishing to fulfill the two-year home country residence requirement.

7. Copy of applicant's curriculum vitae.

8. Notice of Entry of Appearance as Attorney or Accredited Representative (G-28/OMB 1615-0105), if applicable.

9. I-94 Entry and Departure Cards

10. Statement from the facility that salary or other forms of financial support are at a level equivalent to that offered to all other physicians recruited by the facility.

11. Letter of support from the hospital chief of staff where the applicant will have admitting privileges verifying that privileges will be granted or, if not, how admissions of the applicant's patients will be arranged.

12. Letter of support from a local organization or agency such as the chamber of commerce, local health department or other community-based organization.

13. Copy of Illinois medical license or copy of Illinois medical license application.

14. Completed and notarized Certification Statement A signed by the applicant agreeing to the contractual requirements set forth in Section 214 (k)(1)(B) and (C) of the act (copy attached) and Physician Attestation.

15. Completed and notarized Certification Statement B describing applicant's obligation to his/her home country.

16. Completed and notarized Certification Statement C in which the applicant states that his or her medical license has never been suspended or revoked and that he or she is not subject to any criminal investigation or proceedings by any medical licensing authority.

17. Completed and notarized Certification Statement D regarding accuracy of application material.

18. Completed and notarized Certification Statement E regarding specialty status.

Application materials should be mailed to:

Illinois Department of Public Health
Center for Rural Health
535 West Jefferson Street
Springfield, Illinois 62761-0001

Processing of Application by the Illinois Department of Public Health

Upon receipt of the application, staff in the Department's Center for Rural Health will verify completeness of the application. One written request to the applicant (or the applicant's designee) will be made asking for any materials not included in the application. If requested materials are not received within 30 calendar days of the date of the written request or if the supplemental materials do not satisfactorily address the request, the application will be removed from consideration.

In those instances when application materials support such action, a statement signed by the state public health director will be added to the application stating that it is in the public interest of Illinois' underserved areas that a waiver of the two-year home-country residency requirement be granted.

The requesting facility will be notified in writing of the Department's decision on the waiver. If the Department recommends a waiver, the application package will be forwarded to the United States Department of State, Waiver Review Division.

Number of Waiver Applications to be Processed

The act allows the Department to submit 30 waiver requests per federal fiscal year. When the Department has processed the 30 waiver requests allowed, any subsequent applications will be returned to the applicants.

The maximum number of waiver applications processed by the Department for any shortage area will equal the number of physicians needed to reduce the area's population to primary care physician ratio to the Illinois threshold ratio used to designate

rural and urban areas. These thresholds are defined in 77 Ill. Adm. Code Part 590.320(e) http://www.ilga.gov/commission/jcar/admincode/077/077005900D03200R.html.

Selection Process

The following selection criteria will be applied:

1. In the first and second calendar quarters of the federal fiscal year, a maximum of two visa waiver applications will be approved per facility. In subsequent quarters, facilities that have already had two waivers approved may apply for additional waivers; however, selection priority will be given to applications from facilities that have not previously had waivers approved.

2. Preference will be given to the applicant whose position represents the largest proportion of primary care specialty vacancies at the facility offering employment to the physician.

3. Preference will be given to applications received from HPSAs having the greatest unmet need for primary care physicians. Unmet need is the number of primary care physician full-time equivalents needed to cause the HPSA to no longer meet the threshold ratio for HPSA designation.

4. The following selection allocations will be used in processing waiver applications:

    a. In the first and second calendar quarters of the federal fiscal year, six waivers will be reserved for psychiatrists who will serve in rural facilities; 12 of the remaining 24 waivers will be reserved for primary care physicians; 12 waivers will be available to physicians in other specialties.

    b. In the first and second calendar quarters of the federal fiscal year, the Department will reserve 50 percent of the waivers for primary care physicians who will serve in rural areas.

    c. The Department may grant up to five waivers to physicians in other than primary care specialties who will practice at medical facilities that document that at least 51 percent of the participating physicians' patients come from a HPSA or MUA/P.

    d. In the third and fourth quarters of the federal fiscal year, remaining waivers may be used for primary care, psychiatrist and other specialty waiver applicants, both rural and urban.

Semi-annual Verification of Applicant's Medical Practice

Each six months subsequent to the date of the granting of the J-1 waiver by the United States Department of State, Waiver Review Division, the Department shall request written verification of the full-time practice of the applicant in the physician shortage area indicated in the employment contract originally submitted with the waiver application package. If at any time the applicant fails to practice on a full-time basis in the approved shortage area, the Department will notify the Immigration and Naturalization Service of the recipient's breach of obligation.

NOTE: All questions regarding the J-1 Visa Waiver Program should be directed to the Department's Center for Rural Health at 217-782-1624, TTY(hearing impaired use only) at 800-547-0466.

CERTIFICATION STATEMENT A
APPLICANT PHYSICIAN ASSURANCES FOR J-1 VISA WAIVER APPLICATIONS

This is to certify that I, _____
Printed / Typed Last Name First Name Middle

agree to comply with the contractual requirements set forth in Section 214(k)(1)(B) and (C) [8 U.S.C. 1184 (k)(1)], stated below:

> The alien demonstrates a bona fide offer of "full-time" (40 hours) employment at a health care 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)
>
> The alien agrees to practice medicine in accordance with paragraph (2) for a total of not less than three years only in a geographic area or areas, which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals.

I hereby declare and certify, under penalty of the provisions of 18 USC.1001, that: 1) I have sought or obtained the cooperation of the Illinois Department of Public Health which is submitting an IGA request on behalf of me under the Conrad 30 program to obtain a waiver of the two-year home residency requirement; and 2) I do not now have pending nor will I submit during the pendency of this request, another request to any U.S. government department or agency or any equivalent, to act on my behalf in any matter relating to a waiver of my two-year home residence requirement.

_____ _____
Signature of Physician Seeking Waiver Date

Attested by

State of _____

County of _____

Signed or attested before me on _____ (date) by

_____(name of person/s).

_____
Signature of Notary Public

Notary Seal

CERTIFICATION STATEMENT B
CONTRACTUAL OBLIGATION TO HOME COUNTRY

This is to certify that I, _____
Print/Type Last Name First Name Middle

Check one: _____ have _____ do not have
a contractual obligation to return to my home country or country of last residence.

_____ _____
Signature of Physician Seeking Waiver Date

Attested by

State of _____

County of _____

Signed or attested before me on _____ (date) by

_____(name of person/s).

_____
Signature of Notary Public

Notary Seal

NOTE: If you indicated you have a contractual obligation to a country, you are required to obtain a letter from that country stating no objection to you remaining in the United States. You should request this statement from your embassy in Washington, D.C., or from your home country. The letter should be sent to the director of the United States Information Agency through the United States Embassy in your home country. It also can be sent through the foreign country's head of mission or duly appointed designee in the United States to the director of the United States Information Agency in the form of a diplomatic note. This note shall include applicants' full name, date and place of birth, and present address and the language "…pursuant to Public Law 103-416." You should also request a copy of the no objection letter be sent to you for your files.

CERTIFICATION STATEMENT C
MEDICAL LICENSE STATUS

This is to certify that I, _____
Print/Type Last Name First Name Middle

am not subject to any criminal investigation or proceedings by any medical licensing authority, nor has my medical license ever been suspended or revoked.

_____ _____
Signature of Physician Seeking Waiver Date

Attested by

State of _____

County of _____

Signed or attested before me on _____(date) by

_____(name of person/s).

_____
Signature of Notary Public

Notary Seal

CERTIFICATION STATEMENT D
ACCURACY OF APPLICATION INFORMATION

This is to certify that the information presented in this application for assistance from the Illinois Department of Public Health to request a waiver of the home residency requirement for the applicant indicated below is accurate and correct to the best of my knowledge.

Health Care Facility/Agency

_____
Printed or Typed Name

_____
Signature

_____
Title or Position with Facility/Agency

_____
Facility/Agency Name

_____
Date

Applicant

_____
Printed or Typed Name

_____
Signature

_____
Date

Attested by

State of _____

County of _____

Signed or attested before me on _____(date) by

_____(name of person/s).

_____
Signature of Notary Public

Notary Seal

CERTIFICATION STATEMENT E
PRIMARY CARE SPECIALTY

This is to certify that I, _____
Print/Type Last Name First Name Middle

check one: _____ am board eligible _____ am board certified

In the specialty/specialties listed below.

Check applicable specialty:

____ Family Practice ____ General Internal Medicine

____ General Pediatrics ____ Obstetrics/Gynecology

____ Combined Medicine/Pediatrics ____ Psychiatry

____ Other (Specify)_____

_____ _____
Signature of Physician Seeking Waiver Date

Attested by

State of _____

County of _____

Signed or attested before me on _____(date) by

_____(name of person/s).

_____
Signature of Notary Public

Notary Seal