West Virginia Department of HEALTH

Bureau for Public Health
Office of Community Health Systems & Health Promotion
Division of Rural Health & Recruitment
State Office of Rural Health
350 Capitol Street, Room 515
Charleston, WV, 25301-3717
(304) 352-6035

J-1 Visa Waiver Program: End of Obligation Request Letter

An End of Obligation service letter may be requested by a healthcare facility or an immigration law professional representing the healthcare facility on behalf of a J-1 Physician, upon the completion of the physician's service obligation. To formally request a letter, please refer to the attached sample letter, which the healthcare facility or immigration law professional should submit to:

Wendy Castaneda
J-1 Visa Waiver Coordinator for WV State Office of Rural Health
Email: wendy.p.castaneda@wv.gov Phone: (304) 352-6005

Please be advised that the West Virginia State Office of Rural Health (WV-SORH) reserves the right to grant or decline any requests for an End of Obligation letter. To be eligible for this letter, the Physician must have completed their service and submitted their biannual Reporting and Monitoring reports, as well as their Placement Verification form. The letter will be issued and provided electronically to the representative who requested the letter within 2 weeks of the original request date. An individual request letter must be submitted for each physician even if the practicing facility or sponsors are the same.

Header: Healthcare Facility or Immigration professional's company letterhead

Date

RE: Physician Name

To Whom It May Concern,

This letter is to formally request a J-1 Visa Waiver End of Obligation Letter. I, **(Name of Representative)** confirm that **(Physician Name, MD)** has completed their obligation to the State of West Virginia under the Conrad 30 J-1 Visa Waiver Program. **(Physician name, MD,)** began practicing as a (list **Specialty)** physician at ***(Facility name and practice address including County)** on **starting date** and completing their obligation on **(ending date.)**

HPSA #:
MUA#:

If you have any questions, please feel free to contact me at **(Representative's Phone Number)** or at **(Representative's email address)**

Sincerely,

Sponsor Representative's Signature
Sponsor Representative's Name
Sponsor Representative's Title

*Please ensure all site locations are listed precisely as named in the initial waiver application. Waivers and H1B statuses are location-specific; therefore, the sites where service was completed must correspond exactly with those listed in the original application.

Footer: Healthcare Facility or Immigration professional's company letterhead (if applicable)