Department of State Packet Cover Sheet

The information contained in this section includes policies and sample documents that are required for the State of West Virginia to submit to the United States Citizenship and Immigration Service (USCIS) on behalf of a J-1 Visa Waiver physician to receive a waiver of their two-year foreign residency requirements.

USCIS required documents for a completed application packet must include:

_____ **1**. **Data Sheet DS-3035**

_____ **2. Case Number** assigned by the Department of State (DOS) must be located on the bottom right hand corner of every sheet submitted.

_____ **3.** Valid Three (3) year **Employment Contract** to include the following:

_____ **4**. Name, address and geographic area of the health care facility, and the specific geographical area or areas in which the foreign medical graduate will practice medicine.

_____ **5**. Physician must provide primary care, *i.e., general or family practice, general internal medicine, pediatrics, or obstetrics and gynecology,* or specialty medicine in practice sites which are located within the State of West Virginia in a designated Primary Care Health Professional Shortage Area (HPSA); psychiatric care in a Mental Health Professional Shortage Area (MHPSA) or a Medically Underserved Area (MUA).

_____ **6.** Section 214 (l) of the Immigration and Nationality Act (See attached) Certification that physician will provide 40 hours per week, 45 weeks a year (1,800 hours) of the type of care for which their application is being submitted primary care or specialty medicine. Time spend for travel, inpatient care, on-call, or hospital rounds by physicians placed in clinic-based practices will not count towards the 40-hour work week requirement.

_____ **7.** Contract shall not contain a non-compete or restrictive covenant clause.

_____ **8.** Statement which states that the physician's terms of service begin when U.S. Citizenship and Immigration Services (USCIS) grants approval of the physician's waiver or within 90 days of the Immigration and Naturalization Service (INS) approval.

_____ **9. Physician Attestation** (signed by J-1 Physician and seal Notary Public)

_____ **10. DS-2019** (formerly IAP-66)

_____ Physician's current sponsor address
_____ Physician's country of nationality or last permanent address
_____ No time gaps between forms
_____ Physician not out of status for more than 6 months
_____ Evidence that physician residency was done in the United States

_____ **11**. **Employer's Letter** to WV State Office of Rural Health (See attached)

_____ **12. Statement by the Head of the Health Care Facility** (Signed Please)

_____ **13. Personal Statement** from physician regarding his/her reasons for not wishing to fulfill the two-year home country residence requirement to which the Foreign Medical Graduate (FMG) agreed at the time of acceptance of exchange visitor status.

_____ **14**. **Physician's Curriculum Vitae**

_____ Medical Credentials (including a West Virginia Medical License or proof of application to the West Virginia Board of Medicine
_____ Residency Letters of Recommendation

_____ **15. Explanation for Out of Status** if the FMG has spent any period of time in some other visa status, out of status, or outside of the United States. (if applicable)

_____ **16**. **G-28(s)** (if applicable)

_____ For J-1 physician, if attorney so representing
_____ For sponsor, if attorney so representing

_____ **17.** Copies of most recent **I-94 Entry and Departure cards**

_____ **18. "No Objection" Statement** (Public Law 104-416) from the visitor's government if such alien is contractually obligated to return to his or her home country upon completion of the graduate medical education or training, the Secretary of State is to be furnished with a statement in writing that the country to which such alien is required to return has no objection to such waiver. Additionally, this paragraph shall bear a notation that it is being furnished pursuant to Public Law 103-416 (if applicable).

Below are policies and documents that are required by the State of West Virginia to submit a J-1 Visa Waiver physician packet to the Department of State:

_____ **19. West Virginia's J-1 Visa Waiver Policy** signed by both the physician and the sponsor

_____ **20. J-1 Visa Waiver Program Agreement** (Notary Public)

_____ **21. Two complete application packets are submitted.**

NOTE: *West Virginia's J-1 Visa Waiver Program Agreement will be prepared by the Division of WV State Office of Rural Health upon receipt of the completed waiver application.*

Mail applications to: Department of Health
Bureau for Public Health
WV State Office of Rural Health
J-1 Visa Waiver Program Coordinator
350 Capitol Street, Room 515
Charleston, West Virginia 25301-1757
Telephone: (304) 558-4382 or toll-free (888) 442-3456

STATEMENT TO BE INCLUDED IN EMPLOYMENT CONTRACT

The foreign medical graduate agrees to the contractual requirements set forth in section 214(l) of the Immigration and Nationality Act.

PHYSICIAN ATTESTATION

I, _____ (name of exchange visitor) hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1001, that I do not now have pending nor am I submitting during the pendency of this request, another request to any United States Government department or agency or any State Department of Public Health, or equivalent, other than _____ (insert name of State Department of Public Health requesting waiver) to act on my behalf in any matter relating to a waiver of my two-year home-country physical presence requirement.

_____ _____

Date Signature of J-1 Physician

Subscribed and sworn before me this

_____ day of _____, 20__.

_____ (Notary Public)

Notary Seal must be provided

REQUIRED CONTENTS OF WAIVER
LETTER FROM EMPLOYER

Bethlhem Amare, J-1 Visa Coordinator
WV State Office of Rural Health
350 Capitol Street, Room 515
Charleston, West Virginia 25301-1757

Dear Ms. Amare:

1. Name of doctor, medical specialty, any sub-specialty or fellowship training, and type of practice setting in which the doctor will be placed, i.e., primary care clinic-based practice, primary care emergency department-based practice, psychiatry placement in clinic-based practice, or psychiatry placement in mental health hospital (the latter requires a federal facility shortage designation).

2. Employers identify (e.g., Community Health Center (CHC), Federally Qualified Health Center (FQHC), private for profit, private not-for-profit).

3. Complete address of the practice location(s), to include name of the facility, street address, city, county, nine-digit zip code, telephone number, and (if available) email address.

4. A statement and analysis of why the physician is needed. This should include but not be limited to an analysis of the supply of primary care or mental health physicians in the proposed service area(s) versus the patient population in the area(s).

5. Assurance the physician will provide clinical care a minimum of 40 hours per week in the HPSA or MUA. Also, assurance that the 40 hours will exclude time spent on calls, inpatient care, hospital rounds, scheduled after-hour coverage or travel. Time spent on unscheduled emergency room calls during the physicians regularly scheduled clinical hours may be counted toward the basic 40 hour per week clinical obligation. However, such unscheduled emergency room calls are to be considered an exception and shall not become a routine part of the physicians regularly scheduled 40 hour-per-week clinical practice.

6. Certification that the practice site(s) will post a public notice, announcing: the employer's policy to provide medical care to all patients without regard to their ability to pay or their enrollment in Medicaid or Medicare, and that the practice has a sliding fee scale or 'no-charge, no-pay' policy available for those who qualify.

STATEMENT BY THE HEAD OF THE HEALTH CARE FACILITY
DEPARTMENT OF STATE

I certify that the facility at which _____(name of the foreign medical graduate) will be employed is located in an area designated by the Secretary of Health and Human Services as a Medically Underserved Area (MUA), Primary Medical Care Health Professional Shortage Area (HPSA) or a Mental Health Professional Shortage Area (MHPSA).

☐ If your facility is not located in either a HPSA or MUA, check here to apply for a Conrad 30 FLEX 10 Slot.

I further certify that the facility provides medical care to both Medicaid and Medicare eligible patients and indigent uninsured patients.

The identifier number of the primary care HPSA, MHPSA or MUA (as assigned by the Secretary of Health and Human Services) is: _____ Additional identifying numbers for this area are: (Please note only one set of the below numbers is required).

The FIPS county code and census tract or block numbering area number (assigned by the Bureau of the Census)

_____ and _____

OR

Nine-digit zip code of the area where the facility is located:

_____ - _____

Signature: _____

Title: _____

Facility Name: _____

Address: _____

_____

_____

Telephone #: _____

N O T I C E

THIS PRACTICE HAS ADOPTED THE FOLLOWING POLICIES FOR CHARGES FOR HEALTH CARE SERVICES

We will charge people receiving health services at the usual and customary rate prevailing in this area. Health services will be provided at no charge, or at a reduced charge, to people unable to pay for services. In addition, the person will be charged 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 Part A or B of Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act.

We will accept assignment under the Social Security Act for all services for which payment may be made under Part B of Title XVIII ("Medicare") of the Act.

We have an agreement with the State agency which administers the State plan for medical assistance under Title XIX ("Medicaid") of the Social Security Act to provide services to persons entitled to medical assistance under the plan.

WEST VIRGINIA DEPARTMENT OF HEALTH
BUREAU FOR PUBLIC HEALTH
OFFICE OF COMMUNITY HEALTH SYSTEMS AND HEALTH PROMOTION
WEST VIRGINIA STATE OF RURAL HEALTH

West Virginia J-1 Visa Waiver Program
Affidavit and Agreement
Affidavit Section 1

I, _____, being duly sworn, hereby request the West Virginia Department of Health Cabinet Secretary, acting in his/her capacity within the West Virginia Department of Health (WVDH), Bureau for Public Health (BPH), Office of Community Health Systems and Health Promotion (OCHSHP), Division of Rural Health and Recruitment (DRHR) and State Office of Rural Health (SORH) 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:

1. I understand and acknowledge that the review of this request is discretionary and that in the event a decision is made not to grant my request, I hold harmless the WVDH, State Health Contact, any and all WVDH employees, from any action or lack of action made in connection with this request.

2. I further understand and acknowledge that the entire basis for the consideration of my request is the State Health Contact's voluntary policy and desire to improve the availability of primary medical care, mental health, and sub-specialty care in regions designated by the United States Public Health Service (USPHS) as Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs) or a Mental Health Professional Shortage Area (MHPSA) in West Virginia.

3. I understand and agree that in consideration for a waiver, if granted, I shall render primary clinical care, mental health care, or sub-specialty care services to patients including those enrolled in Medicare, Medicaid and the uninsured medically indigent for a minimum of forty (40) hours, per week, within a USPHS designated HPSA, MHHPSA or MUA located in West Virginia. I also understand that if I am a primary clinical care physician this 40 hour shall be exclusive of travel, in-patient care, or hospital rounds. I also understand that clinical practice must be in the clinic, and I am expected to adhere to community standards regarding hospital emergency department coverage. I also understand that primary care physicians may practice full-time in an emergency department if so, approved by the WVDH. Finally, I understand that I am required to commence service not later than ninety (90) days after I receive the necessary approvals by the United States Citizenship and Immigration Services (USCIS) and shall continue for at least three (3) years thereafter.

4. I agree to incorporate all the terms of this J-1 Visa Waiver Affidavit and Agreement into any and all employment agreements. Employment contracts shall not contain a non-compete or restrictive covenant clause.

5. I further agree that any employment agreement I enter pursuant to paragraph 3 shall not contain any provision which modifies or amends any of the terms of this J-1 Visa Waiver Affidavit and Agreement.

6. I understand and agree that all medical care rendered pursuant to paragraph 3 shall be in a Medicare and Medicaid certified hospital or health care clinic or mental health facility which has an open, non-discriminatory admissions policy and that will accept uninsured medically indigent patients on a sliding fee basis, or alternatively, if an emergency department, on a 'no-pay' basis.

7. I expressly understand that this waiver of my foreign service requirement must ultimately be approved by the United States Citizenship and Immigration Services (USCIS), and I agree to provide written notification (J-1 Visa Placement Verification Form) in a manner approved by the WVDH of the specific location and nature of my practice to the West Virginia contact at the time I commence rendering services in West Virginia. The first reporting form will be due thirty (30) days after obligation begins and on a semi-annual basis thereafter.

8. I understand and acknowledge that if I willfully fail to comply with the terms of this J-1 Visa Waiver Affidavit and Agreement, the State Health Contact will notify the West Virginia Board of Medicine with a recommendation that the physician's license be revoked or suspended and a notification to the USCIS, Appalachian Regional Commission (ARC) or Department of State (DOS) that the physician is in non-compliance with the State of West Virginia policy.

9. I hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1001, that I do not now have pending nor am I submitting during the pendency of this request, another request to any United States Government department or agency or any State Department of Public Health, or equivalent, other than the West Virginia Department of Health, to act on my behalf in any matter relating to a waiver of my two-year home country physical presence requirement.

10. I understand, and I agree to meet the requirements set forth in Section 214 (l) (B) and (C) of the Immigration and Nationality Act as amended by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 and subsequent federal laws, rules and regulations.

WEST VIRGINIA DEPARTMENT OF HEALTH
BUREAU FOR PUBLIC HEALTH
OFFICE OF COMMUNITY HEALTH SYSTEMS AND HEALTH PROMOTION
WEST VIRGINIA STATE OF RURAL HEALTH

West Virginia J-1 Visa Waiver Program
Affidavit and Agreement
Agreement Section 2

This AGREEMENT is made and entered into by and between the West Virginia Department of Health, Bureau for Public Health, Office of Community Health Systems and Health Promotion, Division of Rural Health and Recruitment (SORH) also referred to as the "Department" and _____, **MD** or **DO**, also referred to as "Provider".

Whereas, the WV State Office of Rural Health, within the Department's Bureau for Public Health is responsible for administering the WV J-1 Visa Waiver Program, allowing foreign medical graduates to practice medicine in West Virginia for 3 years, in lieu of returning to their country of nationality or last residence to complete a 2-year foreign residency requirement for International Medical Graduates (IMG);

Whereas, the State's J-1 Visa Waiver Program improves access to health care in underserved areas of the State by sponsoring physicians holding J-1 Visa's;

Whereas, the Department has or will through the Appalachian Regional Commission (ARC) or the Department of State (DOS) recommended Provider's application for a waiver of the 2-year foreign residency requirement for IMG's; and,

Whereas, Provider seeks to practice medicine and be employed for three years in the State of West Virginia for_____, in_____ _____West Virginia_____, an underserved area in exchange for completing the 2-year foreign residency requirement.

NOW THEREFORE, in consideration of the foregoing recitals and of the mutual covenants contained herein, the Department and Provider hereby agree as follows:

ARTICLE I. GENERAL TERMS AND CONDITIONS

1. Term of Agreement

The term of this agreement begins the day the J-1 Visa Waiver physician begins employment with the above-named Sponsor. The Provider agrees to provide clinical medical services at _____, _____, _____West Virginia _____ and is effective for thirty-six months.

2. Entire Agreement

This document constitutes the entire agreement between the parties. No amendment or other modification changing this agreement shall have any force or effect unless it is in writing and duly executed by the parties.

3. Conformance with State and Federal Regulations, Governing Laws

This agreement is subject to and governed in all aspects by the laws of the State of West Virginia, and, where applicable, Federal law. Provider at all times will conform to and abide by all applicable Federal and State laws and regulations including but not limited to Equal Employment Opportunity, Federal Rehabilitation Act, Civil Rights Act and any other pertinent Federal, State, or local laws, regulations or policies in the provision of medical services at the location indicated above.

4. Assignment

Provider shall not modify, convey, sell, transfer, assign, delegate, or otherwise dispose of this agreement or any portion thereof or of any right, title, interest or obligation therein without the prior written consent of the Department.

5. Termination of Agreement

The Department may terminate this agreement for cause at any time with thirty (30) days written notice to Provider. The determination of what constitutes cause for termination is at the sole discretion of the Department.

ARTICLE II. PROVIDER RESPONSIBILITIES

6. General Requirements

Provider will:

A. Notify the Department upon approval from United States Citizenship and Immigration Services (USCIS) within 30 days by supplying the Division of Rural Health and Recruitment by returning the J-1 Visa Placement Verification Form. The obligation start date will be the date of employment of the physician by the sponsor.

B. Provide full-time clinical medical care, including care to the indigent at the practice site determined by the sponsor for three years. Full-time practice means providing hands-on, direct patient care for a minimum of 40 hours per week, over a period of 45 weeks per year. The work week must not be compressed to less than four days.

C. Incorporate the terms of the WV J-1 Visa Waiver Policy into any and all Employment agreements.

7. Provider Acknowledgment

By signing this agreement, the Provider acknowledges that he/she has entered into a legally binding agreement and has a legal obligation to fulfill the terms of this agreement and provide full-time clinical medical services at the location named herein or at another location approved by the Department for 3 years.

ARTICLE III. DEPARTMENT RESPONSIBILITIES

8. General Requirements

The Department will:

A. Submit a waiver request to either ARC or DOS on behalf of Provider and Sponsor.

B. Monitor the activities of Provider to ensure compliance with Program requirements.

C. To the extent possible, make provisions for the placement of Provider in another designated underserved site if employment is terminated for reasons beyond his/her control, i.e., closure of the site.

D. Cancel Provider's obligation if he/she should become physically or mentally impaired to the degree that he/she cannot function in his/her assigned duties or should the Provider decease prior to fulfilling his/her obligation.

9. Non-Compliance

Should Provider fail to comply with any of the provisions of this agreement, the Department will report Provider to the West Virginia Board of Medicine with a recommendation that Provider's license be revoked or suspended. In addition, Provider's non-compliance will be reported to the Appalachian Regional Commission and/or the Department of State and the United States Citizenship and Immigration Services.

This agreement becomes effective upon signature of all parties below and will continue in force until such time as modified or terminated as herein provided.

J-1 Visa Waiver Physician Certification:

I have read and fully understand the terms and conditions of the above agreement and the West Virginia J-1 Policy.

Date

Printed Name of J-1 Physician

Signature of J-1 Physician

Employer Certification:

I certify that I have read and understand the above agreement and J1 policy to which this J-1 Visa Waiver Physician's employment to facilitate his/her compliance with these requirements.

Date

Printed Name of Employer

Signature of Employer

Subscribed and sworn before me this _____ day of _____, 20___.

Notary Public Signature

PROVIDER

Provider

Date

STATE OF _____ COUNTY OF _____, To Wit:

I, _____, a Notary Public in and for the aforesaid county, do certify that_____, who signed the above writing, bearing the date _____day of _____, 20___, for _____ has acknowledged the same this day before me.

Given under my hand this _____day of _____, 20___.

My Commission expires _____, 20____.

_____
Notary Public

WEST VIRGINIA DEPARTMENT OF HEALTH

_____ _____
Bethlhem Amare, J1 Visa Coordinator Date
WV State Office of Rural Health

_____ _____
Lisa Lewis, Interim Director Date
WV State Office of Rural Health