



State of Illinois
Illinois Department of Public Health

State 30 J-1 Visa Waiver Program

Revised September 2016

**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>).

Purpose, Authority and Scope

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

The U.S. Department of Homeland Security, Citizenship and Immigration Service (USCIS) may waive the two-year home country requirement upon the recommendation of the U.S. Department of State, Waiver Review Division (USDOS). The Act authorizes the Department to request the USDOS to recommend that USCIS grant the waiver.

The applicant must demonstrate that he/she: has an offer of full-time employment, will begin employment within 90 days of receiving a waiver, and will work for at least three years at a medical facility in an area designated by the U.S. Department of Health and Human Services as having a shortage of health care professionals.

A waiver will not be granted unless the country to which the applicant is contractually obligated to return furnishes USDOS with a written statement that it has no objection to the waiver. State departments of health can request applicants sign a certification statement indicating presence or absence of a contractual obligation to their home country or country of last legal residence.

Physicians

The program accepts applications from all medical specialties. Physicians who apply for a waiver shall:

- 1) reside in Illinois or relocate to Illinois if a waiver is granted;
- 2) be board eligible or board certified in his/her medical specialty; and
- 3) have completed a residency in his/her medical specialty.

Medical Facilities

Medical facilities shall:

- 1) meet the definition of medical facility (see 77 Ill. Adm. Code 591.20);
- 2) be located in a health professional shortage area (HPSA), medically underserved area (MUA) or serve a medically underserved population (MUP) (as applicable). If an applicant applies for a Flex Waiver, documentation must be submitted to demonstrate that at least 51% of the applicant's patients reside in a HPSA, MUA or MUP; and
- 3) be in good standing with the Illinois Secretary of State (see 77 Ill. Adm. Code 591.100(b)(6) and 591.120(b)(2)).

Employers of the medical facility shall not be a relative of the applicant (i.e., spouse, parent, sibling, or child).

Processing Fee

A processing fee of \$3,000 shall accompany each application submitted to the Department (see 77 Ill. Adm. Code 591.115). Payment shall be by check or money order payable to the Illinois Department of Public Health. If the payment does not accompany the application, it will be deemed incomplete. The Department will take no action on the application until the fee has been received. If the payment is not valid due to insufficient funds or other reasons, the application will be null and void. Fee payments are not refundable.

Submission Time Frames

Applications are accepted between October 1 and October 31 of each year. If all recommendations are not made from the applications received in October, applications will be accepted between January 1 and January 31 and between April 1 and April 30, if necessary. Applications will not be accepted after the submission deadlines.

Submission means an application has been received by the Department by the submission deadline. Submission **does not** mean that an application is postmarked by the submission deadline but arrives at the Department on a later date.

Application Package

Application materials are available from the Department's web site at: http://www.idph.state.il.us/about/rural_health/J1_application.pdf. The application shall include the following in the order listed below:

1. A statement from the administrator of the medical facility describing prior recruitment difficulties experienced by the medical facility, the expected practice arrangement for the physician, and the impact on the medical facility and the patients it serves if the waiver is not approved;

2. A copy of the medical facility's Certificate of Good Standing from the Illinois Secretary of State;
3. Documentation of the medical facility's payment policy demonstrating that the physician will accept Medicare/Medicaid patients and will not deny services to anyone because of an inability to pay;
4. A copy of the employment contract between the physician and the medical facility.
 - A) The contract shall include:
 - i) The name and address of the medical facility;
 - ii) The specific geographic area(s) in which the physician will practice;
 - iii) A statement that the contract is for a minimum three year duration;
 - iv) A statement that the physician will practice full-time (40 hours per week).
 - a) For primary care physicians, the statement shall include that the physician will work in the Primary Care HPSA;
 - b) For psychiatrists, the statement shall include that the physician will work in the Mental Health HPSA;
 - c) For specialists, the statement shall include that the physician will work in the HPSA, MUA or MUP. If the medical facility is not in a HPSA, MUA or MUP, the application shall document that at least 51% of the physician's patients come from a HPSA, MUA or MUP.
 - d) A statement that any amendments to the contract will adhere to State and federal J-1 visa waiver requirements;
 - e) A statement that termination of the physician may be only for cause;
 - f) A statement that the physician will begin working within 90 calendar days after receiving the waiver and employment authorization from USCIS; and
 - g) A list of benefits and insurance to be provided to the physician.
 - B) The employment contract shall not include:
 - i) A non-compete clause; or
 - ii) A liquidated damages clause.

- C) If the physician will work at multiple facilities, the contract must contain the above-referenced information for each facility.
5. A statement from the medical facility that the salary or other form of financial support offered to the physician is equivalent to that offered to all other physicians with similar skills and experience recruited by the medical facility;
 6. A letter from the chief medical officer or other high level hospital executive verifying that hospital admitting privileges will be granted to the physician and, if not, how admissions of the physician's patients will be arranged. If the physician will work at multiple hospitals, each hospital must submit this letter in the application;
 7. A letter from at least one local organization or agency, such as the chamber of commerce, local health department, or other community-based organization, demonstrating support for the physician;
 8. A copy of the applicant's Illinois medical license or application for an Illinois medical license;
 9. A copy of the applicant's completed U.S. Department of State, J-1 Visa Waiver Recommendation Application (DS-3035);
 10. A copy of the applicant's curriculum vitae;
 11. A copy of the IAP-66/DS-2019 Form (Certificate for Exchange Visitor J-1 Status) for each year the applicant was in J-1 status;
 12. Copies of the applicant's U.S. Customs and Border Protection I-94 Entry and Departure Cards;
 13. Form G-28, Notice of Entry of Appearance as Attorney or Accredited Representative (if applicable);
 14. A personal statement from the applicant regarding his/her reasons for not wishing to fulfill the two-year country of nationality or country of legal residence requirement;
 15. For specialists, documentation that a shortage exists in their specialty, in the underserved area or for the underserved population. The shortage is determined by creating a ratio of physicians to the population using a listing of physicians in that specialty who provide service in the underserved area or for the underserved population and the population of the underserved area or the number of individuals who comprise the underserved population using the most recent data available. If the ratio of physician to population is less than 1:10,000, a greater shortage of that specialty exists in the underserved area or underserved population. Documentation may include, but not be limited to, the following:
 - A) A listing of specialists who provide service in the underserved area or for the underserved population; or

- B) If there are no specialists who provide service in the underserved area or for the underserved population, the applicant shall provide a summary listing the number of patients in the underserved area who migrated out of the underserved area to seek service. This summary shall be for the most recent 12-month period and shall include the travel time and distance these patients traveled to obtain service.
16. For specialists, documentation comparing wait times for an appointment with a physician of the same specialty in the underserved area or for the underserved population. Documentation may include, but not be limited to, the following:
- A) A listing of specialists who provide service in the underserved area or for the underserved population, including the average wait time for an appointment; or
- B) If there are no specialists who provide service in the underserved area or for the underserved population, the applicant shall provide a summary listing the number of patients who migrated out of the underserved area to seek service. The summary shall be for the most recent 12-month period and shall include the average wait time for an appointment.
17. A completed and notarized Certification Statement A regarding the contractual requirements in Section 214(k)(1)(B) and (C) of the Act;
18. A completed and notarized Certification Statement B describing the applicant's obligation to his/her country of nationality or country of last legal residence. If the applicant has a contractual obligation to return to his her country of nationality or country of last legal residence, the applicant shall obtain a letter from that country stating no objection to the applicant remaining in the U.S.;
- 19) A completed and notarized Certification Statement C attesting that the applicant's medical license has never been suspended or revoked and that he/she is not subject to any criminal investigation or proceedings by any medical licensing authority;
- 20) A completed and notarized Certification Statement D regarding the accuracy of the application materials; and
- 21) A completed and notarized Certification Statement E regarding medical specialty status; and
- 22) Documentation that the medical facility is located in a shortage area (as applicable): <http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>

PHYSICIAN INFORMATION

Name: _____
Last First

Department of State Number (DOS): _____

Gender: _____

Country of Birth: _____

Country of Origin: _____

Country of Residence: _____

I-94 Number: _____ Passport Number: _____

Medical Specialty: _____

Address: _____

City, State, Zip: _____

Email: work: _____ home: _____

Phone: _____

CONTACT INFORMATION

APPLICANT CONTACT

Person who is to receive all correspondence or inquiries regarding the application:

Name: _____

Title: _____

Company Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Fax: _____

E-mail: _____

WAIVER CONTACT

Person who is to receive all correspondence or inquiries subsequent to the issuance of a waiver:

Name: _____

Title: _____

Company Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Fax: _____

E-mail: _____

EMPLOYMENT INFORMATION

EMPLOYER

Include information regarding the physician's employer:

Name of employer: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Fax: _____

Contact person of employer: _____

E-mail of contact person: _____

Employer is (check one):

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Nonprofit Corporation | <input type="checkbox"/> Partnership | <input type="checkbox"/> Other |
| <input type="checkbox"/> For-profit Corporation | <input type="checkbox"/> Governmental Entity | |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Sole Proprietorship | |

MEDICAL FACILITY

Include information regarding the medical facility where the physician will work (if the physician will work at multiple facilities include this information for each facility):

Name of medical facility: _____

Address: _____

City, State, Zip: _____

HPSA ID Number (if applicable): _____

Telephone: _____

Fax: _____

Contact person at medical facility: _____

E-mail of contact person: _____

Submission of Application

An original and duplicate copy of the application shall be submitted to the Department. If a duplicate copy is not submitted, the application will be incomplete.

Applications should be mailed to:

J-1 Visa Waiver Program
Illinois Department of Public Health
Center for Rural Health
535 West Jefferson Street
Springfield, Illinois 62761-0001

Processing of Applications

Upon receipt, Department staff will verify completeness of the application. Completeness is based on whether all applicable requirements have been addressed and whether all required materials and documentation have been submitted.

If complete, the application will be considered for a waiver.

If the application is incomplete, the Department will notify the applicant in writing. The applicant will have 30 calendar days (**from the date of the Department's notification**) to address the issues identified and submit requested information or materials. If the applicant does not respond to the notification within the prescribed time frame or if the supplemental materials or information fail to address the issues identified by the Department, the application will be null and void.

The applicant 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 USDOS.

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 30 waiver requests, subsequent applications will not be considered.

Selection Process

The Department will not begin the selection process until all issues with incomplete applications are resolved.

The following selection criteria will be used:

1. In the first and second calendar quarters of the federal fiscal year, a maximum of two waiver applications may be approved for physicians working at the same medical facility. In subsequent calendar quarters, applications from physicians proposing to work at medical facilities that have already employed two physicians with waivers will be considered; however, selection priority will be given to applications from physicians proposing to work at medical facilities that have not previously employed physicians with waivers.

2. For primary care physicians and psychiatrists:
 - A) Applicants will be ranked based on the Primary Care HPSA score or the Mental Health HPSA score (as applicable) of their respective medical facility. If an applicant proposes to work at more than one medical facility, the Primary Care HPSA score or the Mental Health HPSA score of the medical facility where the applicant will predominately work will be used to rank the applicant.
 - B) If two or more medical facilities have the same HPSA score, preference will be given to the medical facility with the greatest unmet need for primary care physicians and psychiatrists. Unmet need is defined as the number of primary care physician or psychiatrist full-time equivalents needed to cause the HPSA to no longer meet the threshold ratio for HPSA designation.
 - C) An application will not be considered if the inclusion of the applicant will increase the number of primary care physicians or psychiatrists beyond the number needed to eliminate the HPSA designation for the geographic area, facility or population group.
- 3) For specialists:
 - A) Applicants will be ranked based on the HPSA score of their respective medical facility. If an applicant proposes to work at more than one medical facility, the HPSA score of the medical facility where the applicant will predominately work will be used.
 - B) If two or more medical facilities have the same HPSA score, preference will be given to the medical facility having the greatest unmet need for specialty medical care.
 - C) Specialists who applied through the Flex Waiver option shall be ranked based on the greater number of patients that will be seen at the medical facility.
4. The following selection allocations will be used in processing waiver applications:
 - A) In the first calendar quarter of the federal fiscal year, four waivers will be reserved for psychiatrists who will work in rural medical facilities; six waivers will be reserved for primary care physicians who will work in rural medical facilities; seven waivers will be reserved for primary care physicians who will work in urban medical facilities; and 13 waivers will be available to specialists. Of the 13 waivers allocated to specialists, the Department may approve up to 10 waivers under the Flex Waiver option.
 - B) In the second and third quarters of the federal fiscal year, remaining waivers may be used for primary care, psychiatry and specialists in both rural and urban areas.

Semi-annual Verification of Physician's Medical Practice

Each six months subsequent to the date of the granting of the waiver by USCIS, the Department shall request written verification of the full-time practice of the physician in the shortage area indicated in the employment contract originally submitted with the waiver application. If at any time the physician fails to practice on a full-time basis in the approved shortage area, the USCIS will be notified 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 or to dph.crh@illinois.gov

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 must obtain a letter from that country stating no objection to you remaining in the U.S. You should request this letter 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 applicant's full name, date and place of birth, 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

Applicant

Printed or Typed Name

Printed or Typed Name

Signature

Signature

Title or Position with Facility/Agency

Date

Facility/Agency Name

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