OREGON HEALTH POLICY AND RESEARCH
APPLICATION FOR PHYSICIAN VISA WAIVER PROGRAM

U.S. Department of State Case Number *(This number must be obtained prior to submitting application)*	**For OHPR Office Use Only**	
	Date Received:	**Priority Order:**
	Application #:	**Waiver #:**
☐ **Primary Care Application** ☐ **Specialist Application**	**Reviewed by:**	

(Oregon Health Policy and Research (OHPR) will review the application and, if appropriate, and forward it to the U.S. Department of State (USDOS) with an "Approval" recommendation.)

Please Type or Print Clearly - Read all instructions carefully. Complete all sections of this application and attach all required documentation. Incomplete applications will be returned. The Physician and Health Care Facility may work with an immigration attorney to assemble the documents required in this application, and to ensure all other steps are in place that will allow the Physician to live and work in the United States.

Please direct questions concerning the completion of this application to Dia Shuhart, Program Coordinator, at (503) 373-0364 or email dia.shuhart@state.or.us.

DATA SHEET			
Applicant (Health Care Facility)			
Applicant Business Address	City	State	ZIP
Employer Contact Person	Telephone ( )	Fax ( )	
Applicant's Oregon State Business License Number		Applicant's E-mail Address	
Name of Immigration Attorney (if applicable)	Telephone ( )	Fax ( )	
Immigration Attorney Address	City	State	ZIP
Name of J-1 Physician	Or St Medical License #	Home Country	Date of Birth (Mo/day/year)
Physician's Home Street Address	City	State	ZIP
Geographic Location Physician Will Serve	County Census Division, Census Tract or Block Numbering Area		
Population that Physician Will Serve			

1. Is the practice location in one of the following areas?
   ☐Health Professional Shortage Area (HPSA) Identifier # _____
   ☐Mental Health Professional Shortage Area (MH HPSA) Identifier #_____
   (psychiatrists only)
   ☐Medically Underserved Area (MUA) Identifier (if not located in a HPSA)
   # _____ *(requires prior OHPR approval)*
   ☐Medically Underserved Population (MUP) Identifier (if not located in a HPSA)
   # _____ *(requires prior OHPR approval*
   Flex Position not located in HPSA, MUA or MUP (requires prior OHPR approval)

   The HPSA, MH HPSA, MUA and MUP Designations change periodically. Up-to-date information about designations is available on the Internet at http://bphc.hrsa.gov. FIPS County codes and census or block numbering area numbers are assigned by the Bureau of Census and can be found on-line at http://factfinder.census.gov Address Search.

2. Is the proposed practice location an existing facility or a new facility that the Employer will operate? ☐Existing ☐New

   Documentation required: No additional documentation is required for an existing facility. For a new facility only--enclose documentation of the legal, financial, and organizational structure necessary to provide a stable practice environment.

3. Submit documentation that the Health Care Facility has been providing medical care for a minimum of six months prior to submitting this visa waiver application.

4. The Health Care Facility is *(check all that apply)*:
   ☐For Profit ☐Non-Profit ☐Government Organization ☐Community Health Center
   ☐Public Hospital District ☐Other Publicly Funded Provider (specify) _____
   ☐Other *(specify)* _____

   Documentation Required: Submit a report or other documentation that supports the information provided above. The Health Care Facility must currently serve the population specified in the Federal designation. Medicare, Medicaid, and low-income uninsured clients (those with incomes less than 200% of the current Federal Poverty Guidelines).must comprise a minimum of 20% of current total patient visits. Of this 20% total, at least 10% must be Medicaid and low income, uninsured clients. If this position will be filled in a new location or due to expansion of the existing Facility, use data from the existing Facility.

5. Please note the percentage of total patient visits from the preceding six months that your Health Care Facility provided to each of the following populations:

   Medicaid _____% Low Income Uninsured _____% Medicare _____%

   Medicaid Provider # _____

6. Specify the primary language(s) of the underserved population that the Health Care Facility serves:
   _____

7. Does the Health Care Facility have a posted sliding fee discount schedule?
   ☐Yes ☐No

If no, does the Facility agree to implement and post a sliding fee discount schedule for the physician's services? ☐Yes ☐No

Documentation required: Submit a copy of the Facility's sliding fee discount schedule in all posted languages. Sample schedules and notices are available from OHPR.

8. Has the Health Care Facility been recruiting for a minimum of six months from among all qualified physicians that are graduates from U.S. medical schools for this specific position in this specific location? ☐Yes ☐No

   Documentation required: Provide confirmation that Health Care Facility has used public or private recruitment efforts in a broad attempt to fill this position. The Physician Visa Waiver Program should be used as a secondary recruitment effort, and may not replace a viable national search for U.S. medical school graduates.

9. Is the Health Care Facility offering the Physician 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 employment contract between the Health Care Facility and the Physician must outline the working conditions and salary. In addition, a Labor Condition Application (Form ETA 9035), signed and approved by the U.S. Department of Labor, must accompany this visa waiver application.

10. Does the Health Care Facility agree to notify OHPR in writing of the start date of employment? ☐Yes ☐No

    Documentation required: No additional information is required to accompany this application. The Health Care Facility must notify OHPR in writing of the Physician's start date of employment. This start date will be used to determine the dates that six-month status reports are due and the completion date of the J-1 Visa Waiver employment contract obligation.

11. Do the Health Care Facility and Physician agree to provide status reports every six months to OHPR for a period of three years from the start date of employment? ☐Yes ☐No

    Documentation required: A plan showing how the Health Care Facility will obtain and document information for the status reports. The report forms must be completed, signed by both the Facility Director and the Physician, and submitted to OHPR within 30 days following the end of each six-month period after the employment start date. The reports must confirm that at least 20% of the physician's patient visits are Medicaid, Low Income, Uninsured, and Medicare clients. You may access the report form on the Physician Visa Waiver Program website via http://www.oregon.gov/oha/OHPR/Pages/poc/index.aspx.

12. Does the Health Care Facility agree to cooperate in providing requested information needed to clarify or verify the contents of this application, in any investigation of the Facility's financial status, or in any comment received from publicly funded providers? ☐Yes ☐No

13. Does the Health Care Facility agree to allow OHPR auditors access to Facility and Physician records, if OHPR determines it to be necessary? ☐Yes ☐No

    Documentation required: No additional documentation is required at this time.

14. Do the Health Care Facility and the Physician both agree to promptly notify OHPR of any employment-related problems or change in the Physician's employment status, contract, or Facility ownership that occurs during the first three years of employment? ☐Yes ☐No

15. Does the Physician have another application pending with any United state Government agency or any other State, to act on his/her behalf in any matter relating to a waiver of his/her two-year home country residency requirement? ☐Yes ☐No

    Documentation required: No additional documentation required. The federal government will not allow multiple J-1 waiver applications to be submitted simultaneously on behalf of the same physician.

16. Is the Physician contractually obligated to return to his/her home country? ☐Yes ☐No

    Documentation required:

    If yes (to Question 16), then the Physician must obtain a "NO OBJECTION" letter from his/her home country, and it must be mailed directly to the U.S. Department of State. U.S. Department of State recommends the following language:

    "Pursuant to Public Law 103-416, the government of _____ has no objection if (name and address of Physician) does not return to _____ to satisfy the two-year foreign residency requirement of section 212(e) of the Immigration and Nationality Act."

    If this "NO OBJECTION" letter is required, then the letter must be sent directly to the U.S. Department of State, and a copy included with this application.

    If no (to Question 16), 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 accompany this application.

17. Does the Physician have a Letter of Recommendation from his/her residency or fellowship Program Director? ☐Yes ☐No

    Documentation Required: A letter of recommendation from the Program Director must accompany this application. The letter must specifically address the Physician's: (a) interpersonal and professional ability to effectively care for diverse and low-income people in the United States; (b) ability to work well with supervisory and subordinate medical staff; and (c) ability to adapt to the culture of United States health care facilities. The letter must be on the residency program's letterhead and provide contact information for the signatory, including name, title, address, and telephone number.

The following additional documentation is required to process this application. Please verify that all necessary information is included:

A current Curriculum Vitae for the Physician	☐Yes	☐No
All DS 2019 Forms (Certificate of Exchange visitor status)	☐Yes	☐No
G-28 from Attorney (optional)	☐Yes	☐No
U.S. Department of State Data Sheet	☐Yes	☐No
Proof that Physician has passed all INS required examinations	☐Yes	☐No
Copy of Medical Degree (with certified translation)	☐Yes	☐No
Copy of Board Certification/eligibility	☐Yes	☐No
Documentation of current status as a U.S. medical resident/fellow or completion of a U.S. Medical residency/fellowship program	☐Yes	☐No
U.S. Department of Labor, Form ETA 9035 (Labor Conditions Application) signed and approved by the Department of Labor	☐Yes	☐No
Check for $2,000 payable to OHPR/Physician Visa Waiver Program	☐Yes	☐No
Employment Contract `	☐Yes	☐No
Attestation that physician (a) has obtained cooperation of Oregon Health Policy and Research, which is submitting a waiver request on his/her behalf; (b) does not now have any other pending J-1 waiver request; and (c) will not submit any other request while this matter is pending	☐Yes	☐No

I hereby acknowledge that all information and statements contained herein, and in the attached Employment Contract, are true and do not misrepresent facts, per requirements of 18 USC 1001 (Title 18, U.S. Code, Part I, Chapter 47, Section 1001). I further acknowledge that I have not evaded or suppressed any information contained in this application or in any of the supporting materials.

_____ _____
FACILITY REPRESENTATIVE SIGNATURE DATE

_____
(Printed Name)

_____ _____
PHYSICIAN SIGNATURE DATE

Submit two completed application packets. **Both copies** must contain **original signatures** and each application packet must include all required documentation.

Mailing Address: Oregon Physician Visa Waiver Program
1225 Ferry St. SE, First Floor
Salem, OR 97301

EMPLOYMENT CONTRACT REQUIREMENTS

Two contract copies with original signatures must accompany this application. The contract must contain all of the information/conditions outlined below:

- Name and address of the health care facility that will serve as the employer (Include name and address of parent organization, if applicable)
- A complete description of the nature of the Physician's duties.
- Identification of the wages to be paid to the Physician
- 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.
- Employer's agreement to sign all forms required for Physician's H1B status.
- A total service requirement of not less than three years with the employer.
- Statement that the Physician will provide not less than 40 hours per week of patient services in the designated shortage area.
- The specific federal shortage area that the physician will serve, if applicable.
- Statement that the health care facility cannot prevent the Physician from providing patient services in the designated shortage area after the term of employment.
- Statement that the Physician will begin employment within 90 days from the granting of the waiver.
- Statement that the Physician will see all patients, regardless of ability to pay, based on a sliding discount fee schedule implemented by the Health Care Facility. (Note: Physician must serve Medicare, Medicaid and low income, uninsured recipients. A minimum of 20% of patient visits must be Medicare, Medicaid, and low-income uninsured patients.)
- 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.
- Description of either:

  (a) The primary care service that the physician will provide, i.e., Family Practice General Internal Medicine, Pediatrics, OB/GYN; General Psychiatry;

  Or:

  (b) The specialty service that the physician will provide.
- The physician and the person authorized by the Health Care Facility to sign the contract must initial and date all handwritten notes/changes to the contract.

**********END OF APPLICATION**********