State of Illinois
Department of Public Health

State 30 J-1
Visa Waiver Program

Revised September 2023

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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

Under the requirements of the Illinois Freedom of Information Act [5 ILCS 140], all information submitted in support of the J-1 Visa Waiver application, including the employment contract, becomes public record and may be released to the public unless otherwise indicated. Those sections of the application that are confidential or contain proprietary information must be stamped as confidential and include the basis for the confidential claim, in order to protect the record. However, a court may conclude that any records submitted in this process should be disclosed upon request.

Overview

Below is the Illinois Department of Public Health's (IDPH) application process for the J-1 Visa Waiver Program. IDPH's policies can also be found 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 Services (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 IDPH 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) For primary care physicians, have entered into an employment contract with a medical facility located in a Primary Care Health Professional Shortage Area (HPSA). If the

physician will work at more than one medical facility, each facility must be located in a Primary Care HPSA.

2) For psychiatrists, have entered into an employment contract with a medical facility located in a Mental Health HPSA. If the psychiatrist will work at more than one medical facility, each facility must be located in a Mental Health HPSA.

3) For specialists, have entered into an employment contract with a medical facility located in a Primary Care HPSA. If the specialist will work at more than one medical facility, each facility must be located in a Primary Care HPSA.

4) For specialists who apply for the J-1 visa waiver flex option, have entered into an employment contract with a medical facility that is **not** in a Primary Care HPSA.

5) Be board eligible or board certified in his/her medical specialty.

6) 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) For primary care physicians, be located in a Primary Care HPSA.

3) For psychiatrists, be located in a Mental Health HPSA.

4) For specialists, be located in a Primary Care HPSA.

5) For specialists who apply for the J-1 visa waiver flex option, **not** be located in a HPSA.

6) Not be in violation of the additional work location requirements (see 77 Ill. Adm. Code 591.162).

Processing Fee

A processing fee of $3,000 shall accompany each application submitted to IDPH. 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. IDPH 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 waiver 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 IDPH by the submission deadline. It **does not** mean an application is postmarked by the submission deadline but arrives at IDPH on a later date.

Application Package

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. An attestation from each medical facility where the physician will work that it accepts all patients regardless of the ability to pay, accepts Medicaid and Medicare on assignment, and uses a sliding-fee scale based on federal poverty guidelines to discount services to low-income uninsured persons. The attestation must also state that these discounts are offered to all patients of all providers at the medical facility and not only to the patients of the J-1 waiver applicant. This is not required for forensic pathologists who apply for a J-1 waiver and propose to work at a medical examiner's office.

3. A copy of the executed employment contract between the physician and the employer.

    A) The contract shall include:

        i) The name and address of the medical facility where the physician will work. If the physician will work at more than one medical facility, the contract shall contain this information for each facility.

        ii) If the physician will work at more than one medical facility, a statement on which medical facility the physician will predominately work. Predominately means the physician will work at least 21 hours per week at this medical facility.

        iii) A statement that the physician will practice full-time.

        iv) A statement that any amendments to the contract will adhere to state and federal J-1 visa waiver requirements.

        v) A statement that termination of the physician may be only for cause.

        vi) A statement that the physician will begin working within 90 days after receiving the waiver, completing graduate medical education, or receiving employment authorization (whichever is later) from USCIS.

vii) A list of benefits and insurance to be provided to the physician.

viii) A statement that the employer will not add additional work locations without IDPH approval.

ix) A statement that the contract will be in effect for, at a minimum, three years.

B) The employment contract shall **not** include:

i) A non-compete clause.

ii) A liquidated damages clause.

iii) A termination without cause provision.

4. A statement from the employer that the salary offered to the physician is equivalent to that offered to other physicians with equivalent skills and experience recruited by the employer.

5. 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.

6. 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's waiver application.

7. A copy of the physician's Illinois medical license or application for an Illinois medical license.

8. A copy of the applicant's completed U.S. Department of State, J-1 Visa Waiver Recommendation Application (DS-3035)

9. A copy of the applicant's curriculum vitae.

10. 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.

11. Copies of the applicant's U.S. Customs and Border Protection I-94 Entry and Departure Cards.

12. Form G-28, Notice of Entry of Appearance as Attorney or Accredited Representative (if applicable).

13. 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.

14. For specialists who apply through the J-1 visa waiver flex option, documentation that a shortage exists in their specialty for the patients they propose to serve who reside in an

HPSA, that is greater than the norm. 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 HPSA and the population of the HPSA, using the most recent data available. If the ratio of physician to population is greater than 1:10,000, a greater shortage of that specialty exists in the HPSA than is the norm. Documentation may include, but not be limited to, the following:

A) A listing of specialists who provide service in the HPSA.

B) If there are no specialists who provide service in the HPSA, the applicant shall provide a summary listing the number of patients in the HPSA who migrated out of the HPSA 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.

15. For specialists who apply through the J-1 visa waiver flex option, documentation comparing wait times for an appointment with a physician of the same specialty in the HPSA they propose to serve. Documentation may include, but not be limited to, the following:

A) A listing of specialists who provide service in the HPSA, including the average wait time for an appointment.

B) If there are no specialists who provide service in the HPSA, the applicant shall provide a summary listing the number of patients who migrated out of the HPSA to seek service. The summary shall be for the most recent 12-month period and shall include the average wait time for an appointment.

16. A completed and notarized Certification Statement A regarding the contractual requirements in Section 214(k)(1)(B) and (C) of the Act.

17. 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.

18. 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.

19. A completed and notarized Certification Statement D regarding the accuracy of the application materials.

20. A completed and notarized Certification Statement E regarding medical specialty status.

21. Documentation that the medical facility is located in a HPSA (as applicable): Find Shortage Areas by Address (hrsa.gov).

PHYSICIAN INFORMATION

Name: _____
Last First

U.S. Department of State Number (DOS): _____

Gender: _____

Country of Birth: _____

Country of Origin: _____

Country of Residence: _____

I-94 Number: _____

National Provider Identifier (NPI) Number: _____

Medical Specialty: _____

Address: _____

City, State, ZIP: _____
(Provide your nine-digit ZIP code. If you don't know your nine-digit ZIP code, go to this website ZIP Code™ Lookup | USPS).

Email: work: _____ home: _____

Phone: _____

If physician resides in Illinois, provide the following (based on the address referenced above):

U.S. Congressperson: _____

Illinois State Senator: _____

Illinois State Representative: _____

If you need assistance identifying these individuals, go to this website: Find My Elected Officials (il.gov)

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: _____

Email: _____

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: _____

Email: _____

EMPLOYMENT INFORMATION

EMPLOYER

Include information regarding the physician's employer:

Name of employer: _____

Address: _____

City, State, ZIP: _____
(Provide your nine-digit ZIP code. If you don't know your nine-digit ZIP code, go to this website ZIP Code™ Lookup | USPS).

Telephone: _____

Fax: _____

Website: _____

Contact person of employer: _____

Email of contact person: _____

Employer is (check one):

_____ Nonprofit Corporation
_____ For-profit Corporation
_____ Limited Liability Company
_____ Partnership
_____ Governmental Entity
_____ Sole Proprietorship
_____ Other

If employer is located in Illinois, provide the following (based on the address referenced above):

U.S. Congressperson: _____

Illinois State Senator: _____

Illinois State Representative: _____

If you need assistance identifying these individuals, go to this website: Find My Elected Officials (il.gov)

MEDICAL FACILITY INFORMATION

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: _____
(Provide your nine-digit ZIP code. If you don't know your nine-digit ZIP code, go to this website ZIP Code™ Lookup | USPS).

Is this the medical facility where the physician will predominately work? ___ Yes ___ No

Primary Care HPSA Name (if applicable): _____

Primary Care HPSA ID Number (if applicable): _____

Mental Health HPSA Name (if applicable): _____

Mental Health HPSA ID Number (if applicable): _____

Website: _____

Telephone: _____

Fax: _____

Contact person at medical facility: _____

Email of contact person: _____

Provide the following (based on the address referenced above):

U.S. Congressperson: _____

Illinois State Senator: _____

Illinois State Representative: _____

If you need assistance identifying these individuals, go to this website: Find My Elected Officials (il.gov)

Submission of Application

The application shall be submitted to IDPH to this address:

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

or electronically to: dph.j1waiver@illinois.gov

Processing of Applications

Upon receipt, IDPH will verify the 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 applicant will be considered for a waiver.

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

The applicant will be notified in writing of IDPH's decision on the waiver. If IDPH recommends a waiver, the application package will be forwarded to the USDOS.

Number of Waiver Applications to be Processed

The Act allows IDPH to submit 30 waiver recommendations per federal fiscal year. When IDPH has processed 30 waiver requests, subsequent applications will not be considered.

Selection Process

IDPH 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 quarter of the federal fiscal year, a maximum of two waiver applications may be approved for physicians who propose to work at the same medical facility. In subsequent quarters, applications from physicians proposing to work at medical facilities that have already received two waiver recommendations 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 or who do not currently employ a physician with a waiver.

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 Primary Care or Mental Health HPSA score, preference will be given to the medical facility with the greatest unmet need for primary care physicians and psychiatrists (as applicable). Unmet need is 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.

3) For specialists:

   A) Applicants will be ranked based on the Primary Care HPSA score of their respective medical facility. If an applicant proposes to work at more than one medical facility, the Primary Care 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 Primary Care HPSA score, preference will be given to the medical facility having the greatest unmet need for specialty medical care. Unmet need is the number of specialist full-time equivalents needed to cause the HPSA to no longer meet the threshold for HPSA designation.

   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, waiver recommendations will be initially reserved based on the following: four for psychiatrists, six for primary care physicians who will serve at medical facilities located in rural areas, seven for primary care physicians who will serve at medical facilities in urban areas, and 13 for specialists. Of the 13 waiver recommendations initially reserved for specialists, IDPH may approve up to 10 waivers under the Flex Waiver option.

   B) If an insufficient number of applications are submitted to apportion waiver recommendations based on the allocation referenced above, IDPH will take those waiver applications and reallocate them to other categories.

   C) In the second, third, and fourth quarters of the federal fiscal year, remaining waivers may be used for primary care, psychiatry, and specialists to work at medical facilities in both rural and urban areas.

Semi-annual Verification of Physician's Medical Practice

Each six months subsequent to the beginning date of employment, the physician will send to IDPH verification of full-time practice. If at any time the physician fails to practice on a full-time basis in the approved shortage area, USCIS will be notified of the recipient's breach of obligation.

NOTE: Questions regarding the J-1 Visa Waiver Program should be directed to IDPH's Center for Rural Health at 217-782-1624, TTY (hearing impaired use only) at 800-547-0466, or to dph.j1waiver@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 the U.S. Department 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 indicate 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

_____
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
MEDICAL 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