ARKANSAS DEPARTMENT OF HEALTH
J-1 VISA WAIVER PROGRAM

2015-2016 Guidelines

The Arkansas J-1 Visa Waiver Program (Arkansas Program) is committed to improving access to quality, affordable health care for all Arkansans. Therefore, through the Conrad State 30 Program (Conrad Program), the Arkansas Program is prepared to consider recommending a waiver of the two-year foreign residence requirement on behalf of International Medical Graduates (IMGs) holding J-1 visas, provided certain conditions have been met. The Conrad Program allows each state public health department to request up to 30 waivers per year from the United States Department of State (DOS) within their established time period of October 1 through September 30.

As part of the Conrad Program, the Arkansas Program also considers non-designated applications, also known as Flexibility (FLEX) Waivers. Ten of the 30 Conrad slots may be used for IMGs who will practice in facilities not residing in federally designated medically underserved areas, but who service patient populations residing in one or more of these areas. Previously, all 30 Conrad slots required IMGs to practice only in federally designated medically underserved areas. The request for a Conrad State 30 waiver must come from an Arkansas health care facility on behalf of an IMG and not directly from an IMG.

The Arkansas Program Guidelines are completely discretionary, voluntary and may be modified or terminated at any time. Submission of a complete waiver application packet to the Arkansas Program does not ensure that a waiver will be recommended. In all instances, the Arkansas Program reserves the right to recommend or decline any request for a waiver and is not responsible for any practice arrangements or contracts entered into by IMGs prior to or after application to the Arkansas Program.

Applications will be accepted from any rural or metro based facility located in an area(s) designated by the Secretary of the United States Department of Health and Human Services as a Health Professional Shortage Area (HPSA), Mental Health Professional Shortage Area (MHPSA), Medically Underserved Area(MUA), areas with a Medically Underserved Population (MUP) or those having a facility designation as a Federally Qualified Health Center (FQHC), Community Health Center (CHC), public/non-profit HPSA or other HPSA. Primary care as well as any specialty will be considered.

Waiver applications for Conrad Program slots, designated and undesignated, will be reviewed on a first-come-first-served basis beginning October 1, 2015, with a final submission date of September 15, 2016 unless specific permission for a late submission is obtained from the Arkansas Program.

To apply for a non-designated Conrad waiver, be sure to declare that the request is for a "non-designated" position in the first paragraph of the Letter of Need (see enclosed "Application Checklist"). Include documentation that at least 30 % of patient encounters at the application practice site are from HPSA(s) or MUA/P(s). Submit a patient origin study using patient residence zip codes that includes the HPSA and/or MUA/P ID numbers for each zip code provided. Do not identify patients by name, home address or provide any other patient specific information.

Incomplete applications or those not meeting Arkansas Program guidelines will be returned to the sender by FedEx with a letter indicating why the application was not acceptable. Deficient applications may be corrected and resubmitted if the process can be completed by the close date of September 15, 2016. Submissions after the closing date will not be processed unless express permission for a late submission has been obtained from the Arkansas Program. All required information and documentation must be submitted in a single application in the order requested. Applications may not be held open to receive additional document. Documents arriving independent of an application packet may not be matched to an application and may not be considered. The Arkansas Program assumes no responsibility for applications lost in the mail.

Every page of the application must exhibit the IMG's Waiver Review Case File Number as assigned by the DOS. The IMG must sign and have notarized the *IMG Affidavit and Agreement* (enclosed) as part of the application. The *Arkansas J-1 Visa Waiver Application Form* (enclosed) must be completed. The facility's application Letter of Need and any other related correspondence should be directed to the Arkansas Program manager and enclosed in the application.

The IMG must demonstrate a bona fide offer of full-time employment at a health facility in the form of a copy of the complete contract and must agree to begin employment at the facility within 90 days of receiving the United States Citizenship and Immigration Service (USCIS) waiver. The IMG must complete a term of employment of not less than three years providing services, as stated in the contract, for not less than 40 hours per week during normal office hours or hours meeting the needs of the service area, in not less than four days a week. If the employer proposes to use the IMG at more than one site, include the names, locations, designation numbers and schedule of hours at each site where the IMG will practice. All service site areas must be designated. For the non-designated exemption, specific adjacent underserved areas to the practice site must be designated. Contracts may not contain non-compete and/or non-solicitation clauses or other restrictive covenants which would prevent or discourage the IMG from practicing in any Arkansas community after the term of obligation. The IMG must be reimbursed the prevailing wage comparable to other like primary care or specialty providers in the area.

Recruitment and retention efforts must be described in detail. In addition, the employer must demonstrate a reasonable effort to recruit a U.S. doctor for the vacancy, in the same salary range, for at least six months without success prior to application. Include copies of advertisements, agreements with placement services, vacancy announcement letters, medical school postings, etc. If this information is not available submit a strongly worded, detailed statement describing recruitment efforts.

Applications will not be accepted from employers who are IMGs currently fulfilling their waiver obligation. Facilities requesting a placement must be operational at the time of application. These facilities must agree not to discriminate against patients unable to pay for services or those

seeking services under Medicare or Medicaid. A sliding fee schedule, or statement of non-refusal of care based on ability to pay shall be posted in the waiting room and the facility must provide medical care to Medicare and Medicaid eligible patients, as well as the uninsured/indigent.

The Arkansas Program must be notified in writing if the IMG is transferred to another site, additional service sites are added to the IMG's schedule, changes are made in the types of services the IMG is offering or he/she is terminated or leaves for any reason. If at any time the IMG fails to practice on a full-time basis in the approved area/site or areas/sites stated in the contract, the employer must notify the Arkansas Program which will in turn notify the USCIS of the IMG's breach of obligation. Employers are encouraged to impose additional provisions as needed in order to assure delivery of care by the IMG is consistent with their facility's policies and standards.

The Arkansas Program reserves the right to utilize telephone assessments, questionnaires, electronic mail and site visits as necessary to monitor compliance with state/federal guidelines and area/site satisfaction.

An additional sponsorship resource for placing IMGs in Arkansas is the Delta Regional Authority (DRA), an eight-state federal/state partnership that includes 42 counties in eastern and central Arkansas. The DRA accepts waiver applications for primary care and specialty placements. As a federal sponsor, the DRA is not subject to a numerical cap and may process an unlimited number of J-1 waiver applications year round. DRA J-1 Guidelines, as well as a state/county coverage map, are posted on the DRA website: http://www.dra.gov/ (click on the Delta Doctors link), or you may contact Bevin Hunter at (202) 288-6552 or Bhunter@dra.gov .

Note: Prior to submitting a waiver sponsorship request, please check the Arkansas Program Guidelines online at www.healthy.arkansas.gov for updates/changes.

To contact the Arkansas J-1 Visa Waiver Program:

Health Facility Services
J-1 Visa Waiver Program
5800 West 10th Street, Suite 400
Little Rock, AR 72204
Telephone: 501/661-2201 ~ Fax: 501/661-2165

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2015-2016 Waiver Application Checklist

Place requested documents/information in the order shown below.
All information must be included as requested or the application will be returned as deficient

1. **Letter of Need -** From the head of the facility directed to the Waiver Program Manager that must include all of the following:
   - **a.** Letter must be on facility letterhead that includes an address, telephone and fax numbers;
   - **b.** Name and medical specialty of the IMG;
   - **c.** Request that the Arkansas Department of Health act as an interested government agency and recommend a waiver for the IMG named herein;
   - **d.** Describe practice site, nature/extent of services provided and patient demographics;
   - **e.** Description of the IMG's qualifications and proposed responsibilities; and
   - **f.** If submitting a non-designated application, clearly indicate in the first paragraph "non-designated Conrad waiver application" and provide justification for your exemption request.

2. **Arkansas J-1 Visa Waiver Application** – Form enclosed, must be typed and complete.

3. **Employment Contract -** A valid contract of employment must contain all of the following:
   - **a.** IMG's name and medical specialty he/she will practice;
   - **b.** Name/address of employing facility and practice site;
   - **c.** If more than one site, list each site name/address and the days and hours at each;
   - **d.** **List** designation ID numbers for all practice sites or non-designated adjacent areas;
   - **e.** A three-year term of contract effective from the first day the IMG begins working;
   - **f.** State the IMG will work a minimum of 40 hours weekly at approved practice site(s);
   - **g.** List salary and other forms of financial support;
   - **h.** **Statement** that the IMG intends to begin work within 90 days of USCIS waiver approval;
   - **i.** **Statement** that both the employer and IMG agree to comply with the requirements of INA Section 214(l);
   - **j.** The IMG and the head of the health care facility must sign the contract;
   - **k.** The date the contract is signed must be included in the contract; and
   - **l.** Non-compete and/or non-solicitation clauses are not allowed.

4. **IMG Information –** Submit all of the following:
   - **a.** **Curriculum** vitae (CV) with home address, telephone number and email address;
   - **b.** **Copy** of J-1 Visa Waiver Recommendation Application DS 3035 with Supplementary Application Information pages and Waiver Review Bar Code page;
   - **c.** Copy of the DOS Waiver Review File Number notification;
   - **d.** Copies of all DS 2019 Certificate of Eligibility for Exchange Visitor (J-1) Status forms (formerly IAP-66s) in chronological order with most recent first;
   - **e.** Copy of I-94(s);
   - **f.** Proof of passage of examinations required by the USCIS; and
   - **g.** Explanation for any time spent out of status, in some other visa status or out of the U.S.

5. **IMG Affidavit and Agreement –** Form enclosed requiring IMG signature and a notary seal.

6. **Designated Conrad Applications -** Provide documentation that practice site(s) identified in this application are designated as medically underserved by the Secretary of the United States Department of Health and Human Services or serve populations in such areas.

7. N**on-designated Conrad Applications (Flexibility Waivers) -** Provide documentation that at least 30% of the patient encounters at the application practice site(s) are from neighboring HPSA(s) or MUA/P(s) patient populations. Submit a patient origin study using patient residence zip codes that includes the HPSA and/or MUA/P ID numbers for each zip code provided. Do not identify patients by name, home address or provide any other patient specific information.

8. **Indigent Care Provision –** For designated and non-designated sites, a statement signed and dated by the head of the health care facility at which the IMG will be employed stating that the facility(s) accepts Medicare and Medicaid assignment, treats indigent and uninsured patients, uses a sliding fee scale or posts a statement of non-refusal of care based on the ability to pay. Provide Medicaid and Medicare ID Numbers.

9. **No Objection Statement –** If IMG has received funding from his/her home country, attach a statement from the home country stating that they have no objection to the IMG's waiver request.

10. **Document payment of prevailing wage** - For the specialty and area of practice.

11. **Proof practice site(s) is operational –** Practice site(s) named herein must be operational at the time of application.

12. **Recruitment Evidence –** Submit evidence of physician recruitment for a U.S. physician over a six month period or provide a strongly-worded detailed statement describing recruitment efforts.

13. **Retention Plan -** For the IMG beyond the three-year obligation.

14. **G-28 -** If represented by an attorney.

15. **Application Submission -**
    - **a.** All pages of the application must display the IMG's DOS case file number;
    - **b.** Do not include documents that are not required by the DOS or State of Arkansas;
    - **c.** Do not use paper larger or smaller than 8.5 X 11;
    - **d.** Do not use tabs, paper binders or two-sided copies;
    - **e.** Send original application (marked original) and one copy of entire application to:

Arkansas Department of Health
Health Facility Services
J-1 Visa Waiver Program
5800 West 10th Street, Suite 400
Little Rock, AR 72204

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2015-2016 J-1 Visa Waiver Application Form

(Please type or print legibly)

Application Type: Conrad Designated_____ Conrad Non-designated_____ Date: _____

IMG Physician:_____ Female:_____ Male:_____

Last Name First Name Middle Name

Place of Birth:_____ Date of Birth:_____

City Country Month / Day / Year

Nationality: _____ Visa Status: _____ DOS Waiver Review File No: _____

Employer Name:_____ Telephone:_____

Employer Address/City/Zip: _____

Employer Administrator/CEO: _____E-mail: _____

Practice Site Name:_____Telephone:_____

Practice Site Address/City/County/Zip: _____

_____

Additional Practice Site Addresses/Counties: _____

_____

_____

IMG's Medical Specialty: _____ Subspecialty: _____

MUA/MUP ID or HPSA ID for all designated practice sites or non-designated patient populations:

_____

_____

_____

Attorney or Representative:_____

Address: _____

Telephone: _____ E-mail:_____Fax:_____

Note:_____

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2015-2016 IMG Physician Affidavit and Agreement

I_____, being duly sworn, hereby request the Arkansas J-1 Visa Waiver Program to review my application for the purpose of requesting a waiver of the foreign residency requirement as set forth in my current visa, pursuant to the terms and conditions as follows:

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 State of Arkansas, the Arkansas Department of Health, Arkansas State Board of Health members, any and all State of Arkansas employees, agents and assigns from any action or lack of action made in connection with this request.

I further understand and acknowledge that the entire basis for the consideration of my request is the state of Arkansas' voluntary policy and desire to improve the availability of medical care in the federally designated medically underserved areas of the State.

I understand and agree that in consideration for a waiver which eventually may or may not be granted, I shall provide primary or specialty medical care to patients for a minimum of 40 hours per week, in not less than four days a week, within the area or areas stipulated in my employment contract only and which are designated by the Secretary of the United States Department of Health and Human Services as having a shortage of health care professionals, or if I accept a non-designated placement, to a patients residing in a neighboring HPSA(s) or MUA/P(s) as indicated in my employment. I agree to begin employment at such facility within 90 days of receiving such waiver and agree continue to work for a total of not less than 3 years in accordance with paragraph (2), Section 214(l) of the Nationality and Immigration Act.

I agree to incorporate all the terms of this Affidavit and Agreement into any and all employment agreements I enter. I further agree that any employment agreement I enter shall not contain any provision which modifies or amends any of the terms of this Affidavit and Agreement.

I understand and agree that the medical services I will render are in a Medicare and Medicaid certified facility which has an open, non-discriminatory admissions policy and that will accept indigent, uninsured patients.

I expressly understand that this waiver of my foreign residence requirement must ultimately be approved by the United States Citizenship and Immigration Services, and I agree to provide written notification of the specific location and nature of my practice to the Arkansas J-1 Visa Waiver Program upon request.

I understand and acknowledge that if I willfully fail to comply with the terms of this Affidavit and Agreement, the Arkansas J-1 Visa Waiver Program will notify the United States Citizenship and Immigration Services of the United States Department of Homeland Security.

I hereby declare and certify, that I do not now have pending nor am I submitting during the pendency of this request, another request to any state Department of Public Health, or equivalent, other than the Arkansas Department of Health to act on my behalf in any matter relating to a waiver of my two-year home-country physical presence requirement.

I avow that I have never had any medical license suspended or revoked and that I am not subject to any criminal investigation or proceedings by any medical licensing authority.

I declare under the penalties of perjury that the forgoing is true and correct.

Signed_____

IMG Physician Date Type/Print Physician Name

Employer/Facility: _____

Address: _____

_____

Subscribed and sworn to before me

this _____day of _____, 20___

_____

Notary Public