Application for Washington State J-1 Physician Visa Waiver Program

Please type or print clearly and read all instructions carefully. Complete all sections of this application form and attach any additional documentation as needed.

Please review the Application Checklist to ensure all required documentation is provided in the requested order. Incomplete applications will be returned. Please refer to Chapter 246-562 WAC for additional information. The Department of Health (department) suggests, but it is not required, the applicant work with an immigration attorney to ensure all steps are in place that will allow the physician to work in the United States.

If you have questions concerning this application, please contact the J-1 Visa Waiver Program at J1VisaWaiver@doh.wa.gov.

Applications will be accepted October 1st until October 15th of each federal fiscal year to be scored and prioritized based on an annual scoring rubric. Please see the scoring rubric on the department's website for more information. If waiver slots are still available, the department will receive additional applications on a first-come, first-serve basis between November 15th through September 1st of each federal fiscal year until all waiver slots have been filled.

The applicant will be notified of the department's decision. If approved, the department will add the necessary documentation that indicates our intention to act as a sponsor and will forward the application package to the U.S. Department of State. You will be notified by the U.S. Department of State of their approval or denial. The department's approval does not guarantee approval from the U.S. Department of State or the U.S. Citizenship and Immigration Services.

For DOH Office use only		Date received
Date approved:	Reviewed by:	
Application #	Waiver #	

Application for Washington State J-1 Physician Visa Waiver Program

U.S. Department of State Case Number:
(This number must be obtained prior to submitting application)

☐ Primary Care Application
☐ Specialist Application
☐ HPSA waiver
☐ Non-HPSA waiver

Applicant information (The employer is the applicant)			
Name of applicant:			
Mailing address:			
City:		State:	Zip:
Contact during application process:		Phone:	
Washington State Business License Numer (UBI#):		Email:	
Contact for reports and issues following waiver approval, if different than above:		Phone:	
		Email:	

Immigration attorney information (if applicable)			
Name:		Email:	
Mailing address:			
City: ads	State:	Zip:	Phone:

J-1 physician information		
Name:	Email:	Phone:
Home country:	WA State Medical License #	Date of birth:

Proposed practice location(s) for J-1 physician (Attach a list of additional practice locations if necessary)			
Practice street address:			
City:	State:	Zip:	HPSA ID:
Additional address:			
City:	State	Zip:	HPSA ID:

1. **Nature of services to be provided full time by the physician.**
   - ☐ Family Medicine
   - ☐ General Internal Medicine
   - ☐ Pediatrics
   - ☐ Obstetrics and Gynecology
   - ☐ Psychiatry
   - ☐ Geriatric Medicine
   - ☐ Hospitalist (Specialty in which the physician is board eligible and board certified)
   - ☐ Specialist (Identify type of specialty service):
2. **What percentage of hands-on, face-to-face direct patient care will be provided by the physician?**
   - ☐ > 80%
   - ☐ 25-49%
   - ☐ 50-79%
   - ☐ < 24%
3. **What percentage of telehealth will be provided by the physician?**
   - ☐ > 40%
   - ☐ 21-30%
   - ☐ < 10%
   - ☐ 31-39%
   - ☐ 11-20%
4. **What type of facility identifies the practice location?**
   - ☐ State Facility
   - ☐ Federally Qualifies Health Center (FQHC)
   - ☐ Critical Access Hospital (CAH)
   - ☐ Rural Health Clinic (RHC)
   - ☐ Other
5. **Is the practice location located in a rural or urban area?**
   - ☐ Rural
   - ☐ Urban
6. **Is the practice location in one of the following designated HPSA areas? (Check all that apply).**
   - ☐ Population HPSA (Please specify the population) ID#
   - ☐ Mental Health HPSA (For psychiatrists only) ID#
   - ☐ Facility Designated HPSA (e.g. FQHCs, Correctional Facilities) ID#
   - ☐ Geographic Health Professional Shortage (HPSA) ID#
   - ☐ Non-HPSA
7. **What is the HPSA designation score for the practice location?**

   Score:
8. **Has the applicant provided healthcare services at the proposed practice location for at least 12 months prior to submitting this visa waiver application?**
   - ☐ Yes
   - ☐ No

   Note: The applicant must have provided healthcare services at the proposed practice location for at least 12 months prior to submitting this visa waiver application.
9. **Does the applicant have an existing sliding fee discount schedule that is updated to reflect the most recent federal poverty guidelines?**
   - ☐ Yes
   - ☐ No
   - ☐ Applicant does not charge patients (sliding fee discount schedule not required)
10. **Does the practice location have a prominently posted notice for patients that states discounts are available?**
    - ☐ Yes
    - ☐ No
11. **Which of the following new patient payer types is the applicant accepting? (Check all that apply.)**
    - ☐ Medicare
    - ☐ Medicaid (including both fee-for-service and managed care)
    - ☐ Medicare/Medicaid dually eligible
    - ☐ Uninsured patients with a sliding fee discount schedule
12. **During the 12 months preceding this application, did visits by Medicaid clients, Medicare/Medicaid dual eligible clients, and uninsured patients seen using a sliding fee discount scall make up at least 15 percent of the proposed practice location(s) visits?**

☐ Yes ☐ No

Note: A minimum of 15 percent of the practice location's total patient visits must serve Medicaid clients, Medicare clients with Medicaid as secondary insurance and low-income individuals served via the sliding fee schedule.

12-month reporting period:	Total annual patients:	
Patient visits by primary insurance type		
Primary Insurance	**Number of Patient Visits**	**Percentage**
Medicare without Medicaid secondary		
Medicare without Medicaid secondary (dual eligible)		
Medicaid (managed and fee for service)		
Other public insurance (e.g. L&I, county indigent care program)		
Private insurance		
Self-pay with sliding fee schedule discount		
Self-pay (no insurance and not on sliding fee schedule)		
Total		

13. **Is the physician complete with residency or fellowship training?**
    ☐ Yes ☐ No
    If no, please provide the date the physician will complete training:
14. **Did you actively recruit for a U.S. citizen or permanent resident physician candidate for at least six months before signing a contract with the J-1 physician?**
    ☐ Yes ☐ No

Active recruitment period:	Date contract signed with J-1 visa waiver physician:
Recruitment Efforts (Complete sections that apply, leave blank for methods not used in the candidate search)	
Online advertisements	**Time period posted**
National publication advertisements	**Months published**
Contractual agreement with recruiter or recruitment firm	**Date firm began search**
Other (Please describe, attach additional sheet if necessary)	**Time period / Date**

15. **Does the employment contract include any handwritten notes or changes?**
    ☐ Yes ☐ No

16. **Is the applicant offering the physician named in the visa waiver application 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

17. **Please outline the proposed work schedule for the physician below:**

Proposed work schedule for the physician			
Weekday	**Work hours**	**Location**	**Total hours**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
Proposed call schedule:			

18. **Does the applicant agree to notify the Department of Health of any changes made to the employment contract or employment conditions within the first three years from the start date of the physician's employment, which include changes to the: practice location(s); number of hours served by the physician; duties served by the physician; or any changes that would result in a decrease of the physician's wages?**

☐ Yes ☐ No

Note: Any changes made to the employment contract or employment conditions, as outlined above, must be submitted to the Department of Health for review within 30 calendar days after the effective date of the amendment.

19. **Does the applicant agree to notify the Department of Health of the physician's start date of employment**?

☐ Yes ☐ No

20. **Does the applicant and physician agree to provide required annual stat reports to the Department of Health for a period of three years from the start date of employment?**

☐ Yes ☐ No

21. **Does the applicant agree to cooperate in providing the department with clarifying information or information to verify the contents of this application?**

☐ Yes ☐ No

Note: The applicant will be notified by the department if additional information or assistance is needed.

I hereby acknowledge that all information and statements contained herein are true and do not misrepresent facts. I further acknowledge that I have not evaded or suppressed any information contained in this application or in any of the supporting materials.

Applicant Signature Date

_____

Physician Signature Date

_____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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