The Southeast Crescent Regional Commission will administer compliance of the J-1 Visa Waiver Program in three steps:

1. The administrator of the facility and the physician will sign and return the “Physician Employment Verification Form”, within the first week that the physician begins work. Include copies of documentation that physician is in H-1B status including approval notices from USCIS, the physician's I-94 forms and a copy of the H-1B visa stamp from the physician's passport if the physician has already been granted an H-1B visa. If the physician was not licensed in the state of practice at the time the application for the waiver was submitted, a copy of the physician’s state medical license must be included with this form.

2. Compliance Surveys are due on June 15th and December 15th of each year. The surveys will be completed and returned separately to the Commission by both the J-1 physician and the administrator of the facility. The surveys are not identical and will ask confidential questions to both the J-1 physician and the administrator. This survey also requests the number of Medicare, Medicaid, and indigent patients that the facility and the physician has treated in that six-month period, and whether both parties have otherwise complied with the terms of the SCRC J-1 Visa Waiver Program.

   The SCRC has established formal deadlines for these surveys. Both surveys should be returned to the SCRC within 15 business days from the due date. If both surveys are not returned within the initial 15 business days, the SCRC will notify the employer that the survey(s) should be returned within an extension period of 15 business days. If the surveys are not returned within the extension period and if the employer has made no effort or attempt to comply with SCRC Compliance Guidelines, SCRC will notify the appropriate agencies that compliance efforts were unsuccessful and recommend the taking of appropriate enforcement actions.

3. The SCRC or an agent representing the SCRC will conduct unannounced site visits at random during the three-year employment period. If the physician or employer is found
to be out of compliance, the SCRC will immediately notify the appropriate agencies and recommend the taking of appropriate enforcement actions.
J-1 Visa Waiver Program
Physician Employment Verification Form

► This form is not to be submitted with the waiver application but is to be completed and mailed to the SCRC within the physician’s first week of practice.

► Include copies of the physician’s state medical license with this form if they were not included / available at the time the J-1 Waiver Application was submitted. Also include copies of I-94 renewals and approval notices with this document.

► If the physician will be providing services for the employer at different sites than the office site listed below, please provide those addresses on a separate page and attach to this form.

PHYSICIAN:

Name: (print or type) ___________________________ Employment Start Date: __________

I-612 Approval Date: ________________ H-1(b) Approval Date: ________________

Address: Home: ___________________________ Office: ___________________________

Street

Street

________________________ City/State/Zip __________________________ City/State/Zip

________________________ Home Phone __________________________ Work Phone

Physician’s E-mail Address: ________________________________________________

I hereby certify that I, the undersigned, do provide primary health care services at the above stated address for a minimum of 40 hours per week or 160 hours per month.

Physician’s Signature ___________________________ Date: ________________
EMPLOYER:

Name of Employer: ____________________________________________

Address: ___________________________ City/State/Zip: ________________

County: ____________________________

Type of Medical Practice: _______________________________________

(Example: General Practice, Family Medicine, Pediatrics, etc.)

Point of Contact Name: ________________________________________

Phone Number: ___________________________ Email: __________________

I do hereby certify that Doctor _________________________________ is employed by

______________________________ and provides 40

hours of direct patient care per week, or 160 hours per month, at the above stated address.

__________________________________________
Employer’s Signature

__________________________________________
Employer’s Printed Name

__________________________________________
Date
J-1 Visa Waiver Program

Physician Compliance Survey Part A (Employer)

Note: Responses to the questions listed on page two and three are strictly confidential. Only designated staff with the Southeast Crescent Regional Commission will view the responses to those questions.

Year: _____________________       Survey Number: _____________________

Survey Period: ________________       Survey Date: ________________

Name of Physician: __________________________________________

I-612 Approval Date: ________________

H-1(b) Approval Date: ________________

Employment Start Date: ________________

Name of Employer: __________________________________________

Point of Contact: __________________________________________

Phone Number: ____________________________

E-mail Address: ____________________________

Name of Worksite (Please provide data for each worksite): ____________________________

Type of Medical Practice:
(Example: General Practice, Family Medicine, Pediatrics, etc.)

Worksite Address: ____________________________

   Street/Location       City/State/Zip       County
Please indicate the number of patients that the facility has treated in the past six months.

Total No. of Patients: ________________

No. of Private Pay Patients: ___________  % of Total Patients: 0.00%

No. of Medicare Patients: _____________  % of Total Patients: 0.00%
Please indicate the number of patients that the **physician** has seen in the past six months.

Total No. of Patients: __________

No. of Private Pay Patients: __________  % of Total Patients: 0.00%

No. of Medicare Patients: __________  % of Total Patients: 0.00%

No. of Medicaid Patients: __________  % of Total Patients: 0.00%

No. of Indigent Patients: __________  % of Total Patients: 0.00%

No. of Other Patients: __________  % of Total Patients: 0.00%

I do hereby certify that Doctor ________________________________ is employed by ________________________________ and provides 40 hours of direct patient care per week, or 160 hours per month.

Employer’s Signature __________________ Employer’s Name and Title __________________ Date ______________

Please answer the following questions in accordance with the indicated scale:

4=Excellent, 3=Good, 2=Average, 1=Poor

1. How would you rate your overall experience with the physician described above thus far? __________

2. How would you rate the way the physician has followed the terms set forth in the employment contract? __________

3. How would you rate the physician’s ability to communicate effectively with other physicians, nurses, patients, etc.? __________

4. How would you rate the way the physician has been accepted by patients at your medical facility? __________

5. How would you rate the way the physician has been welcomed by the local community? __________
Please use the space provided below to make any positive statement or comment on any problem or concern that you have regarding the physician described above.
J-1 Visa Waiver Program

Physician Compliance Survey Part B (Physician)

Note: Responses to the questions listed on page two and three are strictly confidential. Only designated staff with the Southeast Crescent Regional Commission will view the responses to those questions.

Year: ___________________________  Survey Number: ________________________

Survey Period: ___________________  Survey Date: _________________________

Name: (print or type) ________________________________

Employment Start Date: _________________

I-612 Approval Date: _________________

H-1(b) Approval Date: _________________

Address: Home: ___________________________ Office: ___________________________

Street

City/State/Zip   City/State/Zip

Home Phone   Work Phone

Physician’s E-mail Address: ________________________________________________

Name of Worksite (Please provide data for each worksite): ____________________________

Worksite Address: ___________________________________________________________

Street/Location   City/State/Zip   County

Type of Medical Practice: ___________________________________________________

(Example: General Practice, Family Medicine, Pediatrics, etc.)
Please indicate the number of patients that you have seen in the past six months.

Total No. of Patients: ________________

No. of Private Pay Patients: ____________  % of Total Patients: 0.00%

No. of Medicare Patients: ______________ % of Total Patients: 0.00%

No. of Medicaid Patients: ______________ % of Total Patients: 0.00%

No. of Indigent Patients: _____________  % of Total Patients: 0.00%

No. of Other Patients: ________________  % of Total Patients: 0.00%

Please indicate the number of patients that the facility has treated in the past six months.

Total No. of Patients: ________________

No. of Private Pay Patients: ____________  % of Total Patients: 0.00%

No. of Medicare Patients: ______________ % of Total Patients: 0.00%

No. of Medicaid Patients: ______________ % of Total Patients: 0.00%

No. of Indigent Patients: _____________  % of Total Patients: 0.00%

No. of Other Patients: ________________  % of Total Patients: 0.00%
I hereby certify that I, the undersigned, do provide direct patient care at the above stated worksite(s) for 40 hours per week, or 160 hours per month. I further attest that the information above is truthful and accurate.

Physician’s Signature_________________________ Date:________________

Please answer the following questions in accordance with the indicated scale:

4=Excellent, 3=Good, 2=Average, 1=Poor

1. How would you rate your overall experience with the medical facility described above thus far? ______________

2. How would you rate the way the administrator(s) of the medical facility has followed the terms set forth in the employment contract? ______________

3. How would you rate the way that you have been treated by the administrator(s) of the medical facility described above? ______________

4. How would you rate the way you have been accepted by patients at the medical facility described above? ______________

5. How would you rate the way you have been welcomed by the local community? ______________

Please use the space provided to make any positive statement or comment on any problem or concern that you have regarding the medical facility listed above.
J-1 Visa Waiver Program Physician Compliance Closing Survey

Note: Responses to the questions on this survey are strictly confidential. Only designated staff with the Commission will view the responses to the following questions.

Date: ____________________________

Name: (print or type) ___________________________________________________________

Years Served: ____________ Employment Start Date: ______________

Address: Home: __________________________ Office: __________________________

Street

__________________________ Street

City/State/Zip City/State/Zip

__________________________

Home Phone Work Phone

Physician’s E-mail Address: _____________________________________________________

Name of Employer: ____________________________________________________________

Address: _____________________________________________________________

Street/Location City/State/Zip County

Type of Medical Practice: ____________________________________________________

(Example: General Practice, Family Medicine, Pediatrics, etc.)

I hereby certify that I, the undersigned, provided direct patient care for the above listed employer for 40 hours per week, or 160 hours per month, at a worksite(s) located within a HPSA or MUA. I further attest that the information above is truthful and accurate.
I hereby acknowledge that all information and statements contained herein are true and do not misrepresent facts, per requirements of 18 USC 1001 (Title 18, U.S. Code, Part 1, Chapter 47, Section 1001). I further acknowledge that I have not evaded or suppressed any information contained in this document or in any of the supporting materials.

**Physician’s Signature:**

__________________________________________

**Date:**

__________________________________________
Please answer the following questions:

1. Rate your overall experience with the J-1 Visa Waiver program:
   - [ ] Excellent
   - [ ] Good
   - [ ] Average
   - [ ] Poor

2. Please list any suggestions you may have to improve the experience of the program?

3. Please list any suggestions you have that would have improved your work experience?

4. After your contracted term is complete, do you plan to continue working at the facility?

5. If not, where do you plan to locate and work next?

6. Would you continue to practice medicine? If so, what type of medicine would you practice?

7. Please list the reasons why you are leaving your current location.

8. Please list the reasons that would remain at your current location. (higher salary, becoming a partner in the facility, better community experience, etc.)
Please use the space below to make any positive statement or comment on any problem or concern that you have regarding your overall experience with the J-1 Visa Waiver program:
J-1 Visa Waiver Program

Completion Request Form

Physician’s Name: ___________________________________________

Current Home Address:

Street: ______________________________________________________
City: ________________ State: __________ Zip Code: __________
Home Phone: ______________________________________________
Email Address: _____________________________________________

Employer’s Name: __________________________________________

Street: ______________________________________________________
City: ________________ State: __________ Zip Code: __________
Phone: _____________________________________________________
Email Address: _____________________________________________
Point of Contact: __________________________________________

Worksite(s): Please list additional worksites on Page 3:

Name: ______________________________________________________
Street: ______________________________________________________
City: ________________ State: __________ Zip Code: __________
County: ______________________________
HPSA: ________________________________ MUA: _____

Dates of Employment: _____________ to ______________

Date of Completion: __________________________

I HEREBY CERTIFY THAT I, ________________________________, PROVIDED DIRECT PATIENT CARE AT THE WORKSITE(S) LISTED FOR FORTY (40) HOURS PER WEEK, OR ONE HUNDRED SIXTY (160) HOURS PER MONTH, FOR THREE (3) YEARS.

Physician’s Signature: __________________________

Date: __________________________

I HEREBY CERTIFY THAT DOCTOR ________________________________ PROVIDED DIRECT PATIENT CARE AT THE WORKSITE(S) LISTED FOR FORTY (40) HOURS PER WEEK, OR ONE HUNDRED SIXTY (160) HOURS PER MONTH, FOR THREE (3) YEARS.

Employer’s Signature: __________________________

Date: __________________________
ADDITIONAL WORKSITES

Name: ____________________________________________
Street: ___________________________________________
City: _______________ State: ___________ Zip Code: __________
County: _____________________________
HPSA: _____________________________ MUA: _____

Dates of Employment: ________________ to ________________
Date of Completion: ________________________________

Name: ____________________________________________
Street: ___________________________________________
City: _______________ State: ___________ Zip Code: __________
County: _____________________________
HPSA: _____________________________ MUA: _____

Dates of Employment: ________________ to ________________
Date of Completion: ________________________________

Name: ____________________________________________
Street: ___________________________________________
City: _______________ State: ___________ Zip Code: __________
County: _____________________________
HPSA: _____________________________ MUA: _____

Dates of Employment: ________________ to ________________
Date of Completion: ________________________________
National Interest Waiver Review Checklist

Process Start Date: ________________________________
Date Received: ________________________________

Reviewer Date: ________________________________

Copy of FCC’s Letter File: ☐
Copy of Shipping Receipt: ☐
Emailed Attorney Letter: ☐
Tracking Number: ________________________________

Physician’s Name: _______________________________________
DOS Case Number: _______________________________________
DOB: _______________________________________
Current Address: _______________________________________

Country of Origin: _______________________________________
Specialty: _______________________________________
Worksite Name & Address: _______________________________________


MUA Number:

HPSA Number:

County:

*Provide additional worksites with MUA/HPSA numbers on a separate page.*

Attorney:

Firm Name:

Attorney Address:

Attorney Phone Number:

Attorney Fax Number:

Attorney Email:

Employer’s Name:

Employer Contact:

Employer’s Address:

Employer Phone Number:

Employer Fax Number:

Employer Email:
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Letter of Opinion from Legal Representatives</td>
</tr>
<tr>
<td>2</td>
<td>Form G-28</td>
</tr>
<tr>
<td>3</td>
<td>Physician Statement</td>
</tr>
<tr>
<td>4</td>
<td>Copy of Executed Contract</td>
</tr>
<tr>
<td></td>
<td>□ Signed/dated by Physician/Employer</td>
</tr>
<tr>
<td></td>
<td>□ 5 Year (NIW)</td>
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<td></td>
<td>□ 40 Hours per week or 160 hours per month of direct patient care</td>
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<tr>
<td></td>
<td>□ Service to Medicaid/Medicare/Indigent Patients</td>
</tr>
<tr>
<td></td>
<td>□ Base Salary: __________________________</td>
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<tr>
<td></td>
<td>□ Name of each worksite and address</td>
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<tr>
<td>5</td>
<td>Copies of Diplomas, licenses or applications for licenses</td>
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<tr>
<td></td>
<td>□ State medical license or application for license</td>
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<tr>
<td></td>
<td>□ USMLE Scores</td>
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<tr>
<td>6</td>
<td>Complete passport (Verify all pages)</td>
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<tr>
<td></td>
<td>□ I-129 Immigration Petition Approval Notice</td>
</tr>
<tr>
<td></td>
<td>□ H-1B Approval Notices</td>
</tr>
<tr>
<td></td>
<td>□ Copy of I-94</td>
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</tbody>
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Summary of Reviewer’s Findings:
J-1 Visa Waiver Program

National Interest Waiver Letter of Support Requirements

Each national interest waiver packet must contain the items listed within the SCRC checklist.

If documentation required in the checklist is omitted or does not meet the "Commissions" Program Guidelines, the application will be mailed back to the attorney and will be placed in the back of the current applications that are in the SCRC queue for review. The SCRC checklist should be completed and included in the J-1 visa waiver application to the Commission.

- Send the one application to 15 Lake Drive, Wilson, AR 72395 with a copy of the check and one copy directly to the Southeast Crescent Regional Commission with the check attached
- Place the U.S. Department of State Case Number on all pages.
- Tab the application by the numbers listed below in the following order.

SCRC will make a decision on issuing a support letter upon receipt and review of the following:

Documents required for NIW support letter requested in conjunction with a J-1 waiver:

1. An executed employment contract between the physician and his/her employer, which commits the physician to five years of service in a SCRC underserved county.

2. A statement from the physician’s employer committing support for the physician’s NIW, which should be in the Employer Cover Letter.

3. A short testimonial from the physician expressing his/her reason for pursuing an NIW, which should be expressed in the physician statement.

4. A letter of opinion from a legal counsel stating “to the best of their knowledge, the information in the application is truthful, and that he/she believes the applicant is eligible for a NIW”; this should be stated in the original letter of opinion.
Documents required for NIW support letter requested after waiver has been granted:

1. An executed employment contract between the physician and his/her employer which commits the physician to two or more additional years of service in a SCRC underserved county. Self-employed physicians must present an affidavit committing him/her to two or more additional years of service.

2. A statement from the physician’s employer committing support for the physician’s NIW.

3. A short testimonial from the physician expressing his/her reason for pursuing an NIW.

4. A letter of opinion from a legal counsel stating “to the best of their knowledge the information in the application is truthful, and that he/she believes the applicant is eligible for a NIW.”

5. Copies of diplomas, licenses, board certifications, and USMLE scores.

6. A copy of the physician’s complete passport, I-129 Immigrant petition, H-1B approval notices and I-94.

7. A copy of Form G-28