Oregon Health Authority

Application for Oregon Physician Visa Waiver Program

U.S. Department of State Case #: _____

(Required in order to process application)

Oregon Health Authority will review the application and, if appropriate, forward it to the U.S. Department of State (USDOS) requesting their 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@oha.oregon.gov.

Data Sheet

Applicant (Health Care Facility): _____

Applicant Business Address: _____

Applicant Business City: _____

Applicant Business State: _____

Applicant Business ZIP: _____

Address where physician will work: _____

City: _____

State: _____ ZIP Code: _____

Please enter any additional addresses where the physician will work in this space:

_____

Applicant Contact Person (Name): _____

Telephone: _____

Applicant's email address: _____

Name of Immigration Attorney (if applicable): _____

Telephone: _____

Attorney's email address: _____

Immigration Attorney Address: _____

City: _____

State: _____ ZIP Code: _____

Name of J-1 Physician: _____

10-digit NPI # (Not Medical License #): _____

Home Country: _____

Date of Birth (mm/dd/yyyy): _____

Physician's Home Street Address: _____

City: _____

State: _____ ZIP Code: _____

Physician Personal Email: _____

City, Country of Birth: _____

Location(s) where physician will work: _____

Practice Information

1. In which of the following areas is the practice located? Check all that apply and enter Identifier #s where applicable:

☐Health Professional Shortage Area (HPSA) Identifier #: _____

☐Mental Health Professional Shortage Area (MH HPSA) Identifier #:

_____ (psychiatrists only)

☐Medically Underserved Area (MUA) Identifier #: _____

(Identifier # not required if located in a HPSA; MUA requires prior OHA approval)

☐Medically Underserved Population (MUP) Identifier #: _____

(Identifier # not required if located in a HPSA; MUP requires prior OHA approval)

☐Flex Position not located in HPSA, MUA or MUP (requires prior OHA approval)

HPSA, MH HPSA, MUA and MUP designations change periodically. Information about designations is available online at https://data.hrsa.gov/tools/shortage-area/hpsa-find.

2. Is the proposed practice location an existing facility or a new satellite clinic of an existing facility?

   ☐Yes ☐No

Documentation required: If answer is yes, then no additional documentation is required. For a new employer only – enclose documentation of the legal, financial, and organizational structure necessary to provide a stable practice environment.

3. 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): _____

New employer/change in employer status since last J-1 hire only: Submit a report or other documentation that supports the information provided above. If this position will be filled in a new location or due to expansion of the existing Facility, use data from the existing Facility.

4. Please note the percentage of total patient visits from the preceding six months that your Health Care clinic/hospital provided to each of the following populations. The Health Care Facility must currently serve the population specified in the Federal designation. Oregon Health Plan (OHP) members must comprise at least the current percentage of Medicaid enrollees statewide, to a maximum of 25%. The Medicaid requirements will be adjusted at the start of each program year to reflect the current percentage of Medicaid patients statewide. Alternatively, the total of Medicaid, Medicare and low-income uninsured patient visits must equal more than 50% of all patient visits.

OHP (Medicaid): _____%

Low Income Uninsured: _____%

Medicare:_____ %

Medicaid Provider #:_____ Note: All dual-eligible patient visits count as Medicaid rather than Medicare, regardless of billing or payor.

5. Specify the primary language(s) of the underserved population that the Health Care Facility serves: _____
6. 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 ☐Not applicable

   Documentation required: Submit a copy of the Facility's sliding fee discount schedule in all posted languages. Sample schedules and notices are available on the program webpage.
7. Has the Health Care Facility made a good faith effort to recruit a qualified physician graduate from a U.S. medical school for this specific position in this specific location?

   ☐Yes ☐No

   Documentation required: Health Care Facility’s attempts to actively recruit a United States citizen or permanent resident prior to application submission. 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.
8. 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.

9. Does the Health Care Facility agree to notify OHA 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 OHA in writing of the Physician's start date of employment. This start date will be used to determine the dates that yearly status reports are due and the completion date of the J-1 Visa Waiver employment contract obligation.

10. Do the Health Care Facility and Physician agree to provide status reports every year to OHA 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 or designate and the Physician, and submitted to OHA within 30 days following the end of each year after the employment start date. The reports must confirm either that Medicaid patient visits comprised at least the statewide enrollment percentage, or that the total of Medicaid, Medicare and low-income patient visits comprised more than 50% of the physician's practice. You may access the report form on the Physician Visa Waiver Program website: http://www.oregon.gov.oha.OHPR/PCP/Pages/J1.aspx

11. Does the Health Care Facility agree to provide requested information needed to clarify or verify contents of this application, in any investigation of the Facility's financial status, or in any comment received from publicly funded providers?

    ☐Yes ☐No

12. Does the Health Care Facility agree to allow OHA auditors access to Facility and Physician records, if OHA determines it to be necessary?

    ☐Yes ☐No

13. Do the Health Care Facility and the Physician agree to promptly notify OHA of any problems or potential change in the Physician's employment status, contract, or Facility ownership that occurs during the first three years of employment?

    ☐Yes ☐No

The following additional documentation is required to process this application:

☐A current Curriculum Vitae for the Physician

☐Copy of medical degree or diploma

☐Attestation that physician:

(a) ☐ obtained OHA cooperation, which is submitting a waiver request on their behalf

(b) ☐ does not now have any other pending J-1 request

(c) ☐ will not submit any other request while matter is pending

☐US Department of State 3035 Data Sheet with barcode

☐Employment Contract

☐Check for $2,000 payable to OHA/Physician Visa Waiver Program

☐G-28 from Attorney (if applicable)

☐Letter from the health care facility, signed by CEO, confirming need and intent to hire physician

☐ Please complete Oregon Physician Visa Waiver Program Applicant Demographic Survey. To access the form and more information about the survey, please click here.

I hereby confirm 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, one for submission to US Dept. of State and one file copy.

Mailing Address:

Oregon Physician Visa Waiver Program
500 Summer Street NE E-65
Salem, OR 97301

EMPLOYMENT CONTRACT REQUIREMENTS

The contract must contain all the information/conditions outlined below:

- Name and address of the health care facility where the physician will work (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.
- 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 community after the term of employment.
- Statement that the Physician agrees to begin employment within 90 days from the granting of the waiver.
- Statement that the Physician will see all patients regardless of ability to pay.
    - Medicaid patient visits must meet or exceed the current percentage of Medicaid statewide enrollment, to a maximum of 25%; or
    - (b) Medicaid, Medicare and low-income uninsured patient visits must equal more than 50% of the total.

  The Medicaid requirement will be adjusted at the start of each program year to reflect the current percentage of Medicaid patients statewide.
- Statement by the Physician that he or she agrees to meet the requirements set forth in Section 214 (k) of the Immigration and Nationality Act.
- Description of the primary care or specialist services 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**********