

## J-1 WAIVER PROGRAM CHECKLIST

### IMPORTANT: PLEASE AFFIX THE CASE NUMBER ON EACH PAGE

- ☐ DS-3035 Review Application Form, Data Sheet (current edition) (2 copies).
- ☐ A letter from the head of the organization that wishes to hire the J-1 physician (Original and 1 copy).
- ☐ Signed valid contract of full time employment from the time USCIS grants a waiver of the two-year home-country residency requirement (2 copies).
- ☐ Evidence that the facility is in a federally designated Health Professional Shortage Area (HPSA) or in a Medically Underserved Area (MUA) or that serves a Medically Underserved Population (MUP) (2 copies).
- ☐ Legible copies of the physician's IAP-66/DS-2019 forms, covering every period the physician was in J-1 status. IAP-66/DS-2019 forms must be submitted in chronological order (2 copies of each item).
- ☐ Curriculum Vitae (2 copies).
- ☐ Form G-28 or letter from law office (2 copies).
- ☐ Description of the J-1 physician's proposed responsibilities AND schedule (hours per day and days per week). If the J-1 physician will be assigned to multiple locations, the schedule must include the proposed or estimated hours per day and days per week at each location. Please include a statement of how the J-1 physician's employment will satisfy important unmet needs, including the health care needs of the specific community and preventive programs the physician will initiate or continue that address health problems prevalent in the specific community, etc. (1 copy).
- ☐ Documentation demonstrating unsuccessful recruitment efforts for **at least 6 months or longer** prior to submitting the application and a written description of these efforts. (1 copy of each item)
- ☐ Physician Application (1 original).
- ☐ Service Site Application – one for each service site (1 original).
- ☐ Sliding Discount-to Fee Schedule (SFS), policy/procedure, and SFS Notice (1 copy).
- ☐ Three letters of community support on appropriate letterhead. Letters of support should not be from members or affiliates of the sponsoring organization or service site. (1 original for each letter).
- ☐ Copy of the physician's license or license application (1 copy).

### APPLICATION REVIEW CHECKLIST (FOR ADHS USE ONLY)

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|--|------------|
| <input type="checkbox"/> Administrative review completed   | Date _____ |
| <input type="checkbox"/> Case number on all pages verified | Date _____ |
| <input type="checkbox"/> Need letter/e-mail sent           | Date _____ |
| <input type="checkbox"/> Approval review/score             | Date _____ |