Delta Doctors Program

J-1 Visa Waiver Application Checklist

Name of reviewer:		**Physician's name:**	
Date received:		**DOS case number:**	
Review process start date:		**DOB:**	
Copy of check:		**Country of origin:**	
Date sent to DOS:		**Specialty:**	
Tracking number:		**Current address:**	
Copy of DRA's letter:			
Copy of shipping receipt:		**Phone number:**	
Sent attorney DRA letter:		**Email:**	
Recorded in database:		**HPSA number:**	
Reviewer notes:		**MUA number:**	
		Term:	
		Work site:	
		***Provide additional worksites with HPSA/MUA number(s) on separate page.**	
		County/Parish:	
Attorney:		**Employer name:**	
Firm name:		**Employer contact name:**	

Attorney address:		**Employer address:**	
Attorney phone number:		**Employer phone number:**	
Attorney fax number:		**Employer fax number:**	
Attorney email:		**Employer email:**	

Delta Doctors Program

J-1 Visa Waiver Application Checklist

Two packets are required for submission to the Delta Regional Authority.

Packet 1: Must contain Items 1 through 9.
Packet 2: Must contain Items 1 through 27.

Checklist For DRA use only.	Item #	Required Documentation/Information	Attorney Checklist
☐	**1**	**G-28**	☐
☐	**2**	**Cover letter from employer/facility**	☐
☐		NIW support?	☐
☐		HPSA number:	☐
☐		MUA number:	☐
☐		FIPS number:	☐
☐		Physician information	☐
☐		Medicare/Medicaid/Indigenous pop. (3-year data)	☐
☐		Patient-to-Physician ratio:	☐
☐	**3**	**DOS data sheet and case number sheet**	☐
☐		2 copies?	☐
☐		Case number verified?	☐
☐	**4**	**CV with social Security number**	☐

☐	**5**	**DOS exchange visitor attestation form**	☐
☐		Signed/Dated by physician; Notarized?	☐
☐	**6**	**Copy of executed contract**	☐
☐		Signed/Dated by physician and employer	☐
☐		3-year service? 5-year service (NIW)?	☐
☐		No non-compete clause	☐
☐		160 hours/month of primary/specialty medical care	☐
☐		Service to Medicare/Medicaid/Indigenous pop.	☐
☐		Base salary:	☐
☐		Name and address of each facility:	☐
☐	**7**	**Proof of HPSA/MUA status**	☐
☐		Status verified?	☐
☐	**8**	**IAP-66/DS-2019**	☐
☐		Verify from entry to present	☐
☐	**9**	**Copy of I-94**	☐
☐	**10**	**Letter of opinion from legal representation**	☐
☐		Requesting NIW?	☐
☐	**11**	**DRA J-1 program guidelines**	☐
☐		Signed/Dated by physician and employer	☐
☐	**12**	**DRA affidavit and agreement**	☐
☐		Signed/Dated by physician; Notarized?	☐
☐		All pages included?	☐
☐	**13**	**Proof of prevailing wage data**	☐
☐		Level I:	☐

☐		Level II:	☐
☐	**14**	**Recruiting documentation**	☐
☐		Recruitment overview	☐
☐		National/State/State Medical Schools/Other	☐
☐	**15**	**Letters of community support**	☐
☐		Two (2) local, unaffiliatd physicians	☐
☐		One (1) local elected official	☐
☐	**16**	**Letters of recommendation**	☐
☐	**17**	**Copy of diploma(s), board certification(s), USLME scores, etc..**	☐
☐		State medical license or application for license	☐
☐	**18**	**Proof of existence for each facility**	☐
☐	**19**	**Copy of posted public notice of sliding fee payment for each facility**	☐
☐	**20**	**List of primary care or specialty physicians in county/parish**	☐
☐	**21**	**Passport(s)**	☐
☐	**22**	**Physician statement**	☐
☐		NIW statement (if applicable)	☐
If applicable (i.e. specialty physician):			
☐	**23**	**Sponsor's letter**	☐
☐	**24**	**Service area description**	☐
☐	**25**	**Letter of support – chief medical officer**	☐
☐	**26**	**Letters of support – Two (2) local, unaffilitated primary care physicians, 1 local elected official**	☐
☐	**27**	**Optional: Additional information to support specialty waiver**	☐

Summary of Reviewer's Findings: