DELTA DOCTORS

J-1 Visa Waiver Program

Guidelines

The Delta Regional Authority (DRA) is committed to helping all residents of the Mississippi River Delta Region have access to quality, affordable healthcare to strengthen economic development across the eight-state region. Accordingly, DRA will consider recommending a waiver of the foreign residence requirement on behalf of physicians holding J-1 Visas under certain conditions.

DRA's policy is completely discretionary, voluntary, and may be modified or terminated at any time without notice. In all instances, DRA reserves the right to recommend or decline any request for a waiver. Furthermore, DRA reserves the right for periodic review and possible revision of the program.

DRA encourages its member states to be involved in the agency's J-1 Visa Waiver process because state health agencies are familiar with local health provider shortage issues and opportunities. DRA's process offers states various opportunities for input in the request for the waiver so long as the state agency provides feedback within the timeframe specified by DRA policy.

These guidelines are the requirements with which employers, immigration attorneys, and physician applicants must comply for consideration of a J-1 Visa Waiver recommendation from DRA.

1. The employer's first major prerequisite before requesting a J-1 visa waiver is to make a good-faith effort to recruit an American physician for the opportunity in the same salary range, without success, for a period of 45 days. Recruitment efforts must take place before the employer offers employment to or engages in an employment contract with a physician holding a J-1 visa and no longer than 12 months prior to the submission of the J-1 Visa Waiver application.

   DRA requires evidence of recruitment on three levels: national, in-state, and state medical school recruitment.

   All documentation of advertising and recruitment must be specifically targeted to the employment opportunity (e.g., practice type, specific location, and specific employer).

   Acceptable documentation shall include copies of advertisements for the position published in newspapers, journals, copies of letters to state medical schools, targeted mailings, and/or copies of on-line advertisements that specifically target the practice opportunity. All documentation must include evidence of advertising duration.

Examples of out-of-state publications which are acceptable include newspapers with national circulation (such as *USA Today* or *The Wall Street Journal*) or medical journals (such as *JAMA* or the *New England Journal of Medicine*).

Examples of in-state publications which are acceptable include newspapers with major in-state circulation (such as *The Commercial Appeal*, *The Arkansas Democrat Gazette*, or *The Clarion Ledger*), publications which are circulated in the practice area such as local newspapers/magazines, or in-state medical journals or publications.

2. The physician must agree to provide primary medical care for not less than forty (40) hours per week, or 160 hours per month, at a site in a Health Professional Shortage Area (HPSA), Mental Health Professional Shortage Area (MHPSA), Medically Underserved Area (MUA), or Medically Underserved Population (MUP) as designated by the Secretary of the U.S. Department of Health and Human Services, within the congressionally defined DRA footprint for a minimum of three years or longer. Primary medical care is defined as general or family practice, general internal medicine, pediatrics, obstetrics/gynecology and psychiatry (MHPSA).
   DRA may also make wavier recommendations for physicians who wish to practice specialty medicine, given the following information is provided in addition to the requirements for primary care medicine are met:

   - A letter from the sponsor outlining the reasons a physician or an additional physician with this particular specialty is needed in this area. The letter should contain information describing the particular need for the specialist. The letter shall also contain information concerning the impact of this service not being adequately available to the area, the closest location where this specialty is available if not in this area and whether public transportation is available, and evidence that a physician of this specialty would be viable in the service area;

   - A description of the service area demographics and any other information DRA may use to determine exceptional need for the specialty;

   - A letter of support from the Chief Medical Officer of the facility to which the J-1 physician would provide services to patients addressing the need for this specialty;

   - At least two (2) letters of support from representatives of primary care centers and primary care physician practices (not affiliated with the sponsor) in the area addressing the need for this specialty; and

   - Any additional evidence that would demonstrate the shortage and need for the specialist, such as letters of support from other physicians of the same specialty or local health officers in the service area.

3. The employment contract between the physician and the employer shall not contain a non-compete clause or any other restrictive covenant enforceable against the foreign medical graduate after the tenure of the contract period.

4. The physician shall provide a copy of his or her state medical license or provide evidence of the filing of a license application. A copy of the state medical license must be received by DRA by the time the "Physician Employment Verification Form," is filed in the first week the physician begins work.

5. The physician shall provide DRA with copies of all of his or her Certificates of Eligibility for Exchange Visitor (J-1) Status, forms IAP-66/DS-2019, and any other documentation needed to verify status.

6. It is federal policy that the facility or practice sponsoring the physician must agree to provide health services to individuals without discriminating against them because: (a) they were unable to pay for those services or (b) payment for those health services will be made under Medicare and Medicaid, or a state equivalent indigent health care program. Furthermore, the facility should provide care on a sliding fee payment arrangement for uninsured, low income patients and have this notice publicly posted in the facility.

   Therefore, the application must include a statement, signed and dated by the head of the healthcare facility at which the foreign medical graduate will be employed, addressing the following:

   - The facility is located in DRA's congressionally-mandated footprint and designated by the Secretary of the U.S. Department of Health and Human Services as a Health Professional Shortage Area (HPSA), Mental Health Professional Shortage Area (MHPSA), Medically Underserved Area (MUA), or Medically Underserved Population (MUP), including the shortage designation identification number.

   - The facility's recent history serving Medicare, Medicaid and medically indigent patients by providing patient data for the three most-recent years of service as well as their continuing intentions to serve such individuals.

   - The current patient-to-physician ratios in the practice area, which should be described geographically and demographically in detail in the statement.

   - The name of the physician, area of study, and how these skills will impact patients at this facility.

7. The physician and employer must sign the DRA "J-1 Visa Waiver Program Guidelines." The physician must sign and have notarized the DRA "J-1 Visa Waiver Program Affidavit and Agreement" prior to consideration by DRA of the request and must comply with the terms and conditions set forth in those documents.

8. All requests approved initially by DRA and approved subsequently by the U.S. Citizenship and Immigration Service will be subject to the periodic review by DRA for compliance with this policy statement and other applicable laws. An employer's failure to comply in good faith with this waiver policy will be considered in the evaluation of other applications involving the same employer.

9. DRA does not provide letters of support or no objection for any instances of change in employment status since the agency cannot and does not determine extenuating

circumstances. On a case-by-case basis, DRA will consider providing letters of support for previously-recommended physicians seeking to add another eligible healthcare facility to their list of work sites.

10. If the employment contract specified in Section 2 provides for a minimum of five years employment, DRA will accept a request for a National Interest Waiver (NIW) support letter.

11. The J-1 physician shall submit a personal statement indicating the reasons for not wishing to fulfill the two-year home country residence requirement to which the physician agreed to at the time of accepting the exchange visitor status.

12. DRA's J-1 Visa Waiver Application Package should include an application processing fee in the amount of $3,000.00. This fee will be non-refundable. A partial refund request may be submitted to DRA in writing if, and only if, the application is withdrawn within twenty calendar days after DRA receives the application. If the request is granted, only fifty percent of the application processing fee will be refunded. Make check or money order payable to the Delta Regional Authority.

13. DRA will strive to use the respective states' patient-to-physician ratio to place physicians in those respective states. However, in special need situations, DRA reserves the right to use a minimum patient-to-physician ratio of 2,000 to 1 to qualify the physician for placement.

14. DRA does not expedite the review of J-1 Visa Waiver Application Packages. Please allow at least 60 business days for processing.

I have read, fully understand, and comply with the policies and provisions set forth in this document by the Delta Regional Authority

_____ _____

Physician's Signature Date

_____ _____

Employer's Signature Date

Delta Regional Authority
J-1 Visa Waiver Program

Affidavit and Agreement

I, _____, being duly sworn, hereby request the Delta Regional Authority (DRA) to review my application for the purpose of recommending a waiver of the foreign residency requirement set forth in my J-1 Visa, pursuant to the terms and conditions as follows:

1. I understand and acknowledge that the review of this request is discretionary and that in the event a decision is made not to grant my request, I hold harmless DRA, the Federal Co-Chairman, any and all DRA employees and representatives from any action or lack of action made in connection to this request.

2. I further understand and acknowledge that the entire basis for the consideration of my request is DRA's desire to improve the availability of primary and specialty medical care in areas designated by the Secretary of the U.S. Department of Health and Human Services as a Health Professional Shortage Area (HPSA), Mental Health Professional Shortage Area (MHPSA), Medically Underserved Area (MUA), or Medically Underserved Population (MUP) within DRA's congressionally-mandated footprint. I understand DRA only provides J-1 visa waiver recommendations for physicians practicing at work sites located within DRA's congressionally-designated footprint, and I agree to practice therein. Furthermore, I understand the sponsorship of any waiver by DRA is strictly voluntarily.

3. I understand and agree that in consideration for a waiver, which eventually may or may not be granted, I shall render primary or specialty medical care services to patients, including the indigent, for a minimum of forty (40) hours per week, or 160 hours per month, within a designated HPSA, MUA, MHPSA, or MUP located within DRA's congressionally-mandated footprint. Unless there are extenuating circumstances which DRA approves, such service shall commence no later than 90 days after I receive approval by USCIS of my waiver request and shall continue for a minimum of three years or longer in accordance with the employment contract.

4. I understand and acknowledge that DRA does not provide letters of support or no objection for any instances of change in employment status. DRA cannot and does not determine extenuating circumstances.

5. I agree to incorporate all the terms of this "J-1 Visa Waiver Affidavit and Agreement" into any and all employment agreements I enter pursuant to paragraph 3 and to include in each such agreement DRA's liquidated damages clause, payable to the employer (a copy of all employment agreements are attached to this request). This damages clause shall be activated by my termination of employment, initiated by my employer for cause or by me for any reason, only if my termination occurs before fulfilling the minimum three-year service requirement. In the event of a transfer under DRA's liquidated damages clause, a transfer notification form must be obtained by DRA. I will ensure that this form is completed and returned to DRA with a copy to the State Contact.

6. I further agree that any employment agreement I enter pursuant to paragraph 3 shall not contain any provision, which modifies or amends any of the terms of this "J-1 Visa Waiver Affidavit and Agreement."

7. I understand and agree that I will provide health services to individuals without discriminating against them because: (a) they are unable to pay for those services or (b) payment for those health services will be made under Medicare or Medicaid.

8. I have read, signed, and fully understand the "DRA J-1 Visa Waiver Program Guidelines", a copy of which is attached to this request.

9. I expressly understand this waiver of my foreign residence requirement must ultimately be approved by the USCIS, and I agree to provide placement notification of the specific location and nature of my practice to DRA when I commence rendering services within DRA's congressionally-mandated footprint.

10. I declare and certify, under penalty of the provisions of 18 U.S.C. 1101, that I do not have pending nor am I submitting during the pendency of this request, another request to any United States Government department or agency or any State Department of Public Health, or equivalent, other than DRA to act on my behalf in any matter relating to a waiver of my two-year home-country physical presence requirement.

11. I understand and acknowledge that if I willfully fail to comply with the terms of this "J-1 Visa Waiver Affidavit and Agreement," DRA's Office of the Federal Co-Chairman will notify the USCIS that I am out of compliance. Additionally, any and all other measures available to the Office of the Federal Co-Chairman will be executed in the event of my non-compliance.

I declare under the penalties of perjury that the foregoing is true and correct.

Physician's Signature: _____

Physician's Name: _____

Subscribed and sworn before me this _____ day of _____, 20_____.

_____ (Notary Public)

LIQUIDATED DAMAGES CLAUSE

Any breach or non-fulfillment of conditions will be considered a substantial breach of this agreement by you. If there is such a breach _____ (Employer) may, at its option, terminate this agreement immediately. In addition, it is agreed that _____ (Employer) will be substantially damaged by your failure to remain at _____ (Employer/Facility Name) in the practice of medicine for a minimum of three years and that, considering that precise damaged are difficult to calculate, you will agree to pay _____ (Employer) the sum of $250,000.00 if you fail to fulfill any portion of your minimum three-year contract. Should you perform any portion of the employment contract, you agree to pay a pro rata share based upon the number of months you failed to fulfill (i.e. $6,945.00 per month). In addition to liquidated damages, _____ (Employer) will recover from you any other consequential damages, and reasonable attorney fees costs and expenses, due to the failure to provide services to _____ (Employer) for a minimum of three years, EXCEPT THAT, the full-time practice of medicine at another licensed medical facility, in Health Professional Shortage area (as defined by the United States Public Health Service) with the Delta Regional Authority (as defined by DRA) shall be considered the same a fulltime practice of medicine at _____ (Employer) for purpose of this paragraph. In the event of a dispute under this paragraph, either party may submit this matter to binding arbitration.

The parties agree in consideration of compliance with the forgoing, to indemnify and hold harmless the Delta Regional Authority and / or any person, firm or corporation now or hereafter acting as agent for the DRA in any capacity, and any successors in any such capacities and successors and assigns of DRA, from and against any loss, claim, damage and expense in connection with, or arising out of, compliance with the waiver application set forth herein or any other litigation.

Re: Additional Liquidated Damages Clauses

Any other clause mandating consequential or liquidated damages being paid to the employer must be separate for the DRA clause. DRA takes no position with respect to the inclusion of such an additional contractual agreement.

Physician's Signature: _____

Employer's Signature: _____

Subscribed and sworn before me this _____ day of _____, 20_____.

_____ (Notary Public)

Delta Doctors Program

Waiver of Liquidated Damages Clause Requirement

_____ (Employer) and _____ (Physician) hereby agree to waive the Liquidated Damages Clause required by Delta Regional Authority (DRA) as set forth in the Delta Regional Authority J-1 Visa Waiver Program Affidavit and Agreement.

DRA takes no position with respect to the inclusion of any other clause mandating consequential or liquidated damages being paid to the employer.

_____	_____
Physician's Signature	Employer's Signature
_____	_____
Date	Date

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 U.S. Department of State and to the Delta Regional Authority.

Packet 1: Must contain Items 1 through 10.
Packet 2: Must contain Items 1 through 27.

Checklist For DRA use only.	**Item #**	**Required Documentation/Information**	**Attorney Checklist**
☐	**1**	**Form G-28 – Notice of Entry of Appearance as Attorney or Accredited Represenative**	☐
☐	**2**	**Cover letter from employer/facility**	☐
☐		NIW support?	☐
☐		HPSA number:	☐
☐		MUA number:	☐
☐		FIPS number:	☐
☐		Physician information	☐
☐		Medicare/Medicaid/Indigent pop. (3-year data)	☐
☐		Patient-to-Physician ratio:	☐
☐	**3**	**DS-3035 and Supplementary Applicant Information Pages**	☐
☐		Statement of Reason?	☐
☐		Third Party Barcode?	☐
☐		Waiver Division Barcode?	☐

☐		Case number verified?	☐
☐		2 copies?	☐
☐	**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/Indigent population	☐
☐		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**	**Recruiting documentation**	☐
☐		Recruitment overview sheet	☐
☐		National/State/State Medical Schools/Other	☐
☐	**11**	**Letter of opinion from legal representation**	☐
☐		Requesting NIW?	☐
☐	**12**	**DRA J-1 program guidelines**	☐

☐		Signed/Dated by physician and employer	☐
☐	**13**	**DRA affidavit and agreement**	☐
☐		Signed/Dated by physician; Notarized?	☐
☐		All pages included?	☐
☐	**14**	**Proof of prevailing wage data**	☐
☐		Level I:	☐
☐		Level II:	☐
☐	**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:

J-1 Visa Waiver Program

Application Requirements

Each J-1 Visa waiver application packet must contain the items listed within the DRA checklist.

If documentation required in the checklist is omitted or does not meet the "Delta Doctors" 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 DRA queue for review. The DRA checklist should be completed and included in the J-1 visa waiver application to the Authority.

- Send **Packet 1** *(Items 1-10)* and **Packet 2** *(Items 1-27)* directly to Delta Regional Authority.
- Place the U.S. Department of State Case Number on all pages.
- Tab the application by the numbers listed below in the following order.

Please send the application processing fee (check or money order) of $3,000.00, payable to Delta Regional Authority, to:

Delta Regional Authority
Attn: Kemp Morgan
236 Sharkey Avenue, Suite 400
Clarksdale, MS 38614

1. Form G-28 – Notice of Entry of Appearance as Attorney or Accredited Represenative

2. Cover letter
   The employer shall submit a cover letter with original signature, on the facility's letterhead. The cover letter should be addressed to the Delta Regional Authority and state the facility is in a designated shortage area, provide the shortage area identifier number, and the Federal Information Processing Standards (FIPS) county code and census tract or block numbering area, and physical address for each worksite. The cover letter should also include patient data for the facility to include numbers and percentages of Medicaid, Medicare, and Uninsured patients served for the past three years. The cover letter should also outline details from the sponsor specifically outlining what services the physician will provide to the citizens in the facility's service area and how their training will impact

the patients in this service area. Furthermore, this letter also must contain current patient to physician ratios in the practice area.

3. DS-3035 and Supplementary Applicant Information Pages
   (2 copies of each) (Applicant must have Case Number prior to submitting application.)

4. Curriculum Vitae, including Social Security Number

5. Notarized Department of State Exchange Visitor Attestation Form

6. Copy of executed employment contract. The employment contract should include:

   a. Name and address of each worksite

   b. 3-year service term commitment

   c. 40 hours per week or 160 hours per month of direct patient care

   d. Base salary amount

   e. No non-compete clause beyond the service term

   f. Language regarding care to patients utilizing Medicare, Medicaid, and indigent patients

   g. Employer and employee signature and date

7. Proof of current HPSA, MUA, MUP or MHPS
   A designation for community by worksite address.

8. Readable copies of J-1's IAP-66/DS-2019 forms
   (For entire period in J-1 Status; from entry to present.)

9. Copy of Form I-94
   (Front and back)

10. Documentation of employer's regional and national recruitment efforts
    Include a recruitment overview letter from the employer outlining the recruitment efforts and responses to advertisements placed for physicians. This letter should include recruitment duration dates, forms and kind of recruiting done, and responses received from those recruitment efforts.

    As stated in the DRA J-1 Visa Waiver Program Guidelines, advertisements should be conducted at three levels:

    a. in publications which are national in scope,

b. in-state publications, and

c. written notifications to the respective state's medical schools.

Documentation should include copies of advertisements for this job published in newspapers, journals, state medical schools, mail-outs, etc., and other supporting documentation which demonstrates good faith efforts in giving American physicians an opportunity to apply.

Examples of out-of-state publications which are acceptable include newspapers with national circulation (such as the USA Today or The Wall Street Journal) or medical journals (such as JAMA or the New England Journal of Medicine).

Examples of in-state publications which are acceptable include newspapers with major in-state circulation (such as The Commercial Appeal, The Arkansas Democrat Gazette, or The Clarion Ledger), publications which are circulated in the practice area such as local newspapers/magazines, or in-state medical journal or publications.

11. Letter of Opinion from Legal Representation
    The attorney submitting the J-1 Visa waiver application should submit a letter of opinion to the Delta Regional Authority simply stating that to the best of their knowledge the information in the application is truthful, and that he / she believes the applicant is eligible for the J-1 visa waiver and an ensuing H-1B visa. The letter shall further state that to the best of their knowledge the facility in the application has followed all rules and regulations outlined by the Delta Regional Authority policy to request a J-1 Visa Waiver for a physician the facility wishes to employ.

12. DRA's J-1 Policy Guidelines
    (Signed and dated by employer and physician; original signatures required.)

13. J-1 Affidavit and Agreement
    (Signed and notarized by the physician. Include all Pages of Document)

14. Proof of Prevailing Wage Data
    (From the U.S. Department of Labor indicating the Level I and Level II wage for the position in the practice area.)

15. Letters of community support (For Primary Care Physicians Only)
    The application must include at least three letters of support. A minimum of two letters must be provided by practicing physicians in the area who are permanent residents or U.S. citizens and are not affiliated with the sponsor or worksite. The other letter(s) may come from community leaders or local elected officials. Letters shall be addressed to the Federal Co-Chairman of the Delta Regional Authority. No form letters.

16. Letters of recommendation
    Letters may come from those who know the J-1 physician's qualifications, such as medical directors who oversaw the physician's residency training. Letters shall be addressed to the Federal Co-Chairman of the Delta Regional Authority. No form letters.

17. Copies of physician's diplomas, licenses, board certifications, USMLE scores, etc.

18. Current proof of existence for each facility
    (Facilities must provide proof of existence such as business license, occupancy permit, phonebook listing, or website information.)

19. Copy of facility's posted public notice of sliding fee payment arrangement.

20. List of all physicians in the county/parish serving in the same capacity as the J-1 visa waiver applicant.

21. Copy of complete passport
    (Including all blank pages)

22. Physician Statement
    A personal statement from the physician stating the reasons for not wishing to fulfill the two-year country residence requirement to which the physician agreed to at the time of accepting the exchange visitor status. The statement should further include the physician's reasons for practicing in this particular field of medicine, how their expertise could impact the patients in the locality, and the reasons for accepting the employment contract with the facility in the application.

    If the physician is requesting a waiver to practice specialty medicine, the following information (items 23-27) must be provided in addition to items 1-22.

23. Sponsor's Letter
    A letter from the sponsor outlining the reasons a physician or an additional physician with this particular specialty is needed in this area. The letter shall also contain information concerning the impact of this service not being adequately available to the area, the closest location where this specialty is available if not in this area, whether public transportation is available, and evidence that a physician of this specialty would be viable in the service area.

24. Service Area Description
    A description of the service area demographics and any other information the DRA may use to determine exceptional need for the specialty. Reliable service area descriptions include information from community assessment surveys, the U.S. Census Bureau, and other reputable agencies. Wikipedia is not considered a reliable source.

25. Chief Medical Officer Letter of Support
    A letter of support from the Chief Medical Officer of the facility to which the J-1 Physician would provide services to patients speaking to the need for this specialty.

26. Letters of Support
    The application must include at least three letters of support. At least two (2) letters of support from representatives of primary care centers and primary care physician practices (not affiliated with the sponsor or the worksite) in the area speaking to the need for this specialty. The other letter may come from community leaders or local elected officials. No form letters.

27. Additional Information to Support Specialty Waiver Request
    Any additional evidence that would tend to show the shortage and need for the specialist, such as letters of support from other physicians of the same specialty or local health officers in the service area.

Application Timeline

- Applicants must submit **Packet 1 (Items 1-10)** and **Packet 2 (Items 1-27)** to the Delta Regional Authority.

- DRA will make a recommendation on the J-1 Visa Waiver application within 60 days of the receipt of a complete application. If approved, the DRA will forward the application to the U.S. Department of State. The time period may be extended to allow for additional investigation.

- DRA does not expedite the review of applications.

U.S. Department of State

Exchange Visitor Attestation

I, _____, hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1001, that I do not now have pending, nor am I submitting during the pendency of this request, another request to any U.S. Government department or agency or any other State Department of Public Health, or any equivalent, other than the Delta Regional Authority, to act on my behalf in any matter relating to a waiver of my two-year home-country physical-presence requirement.

_____ _____

Signature Date

Subscribed and sworn to before me This _____ day of _____, 20___.

_____

Notary Public

J-1 Visa Waiver Program

Compliance Guidelines

The Delta Regional Authority 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 30th and December 31st of each year. The surveys will be completed and returned separately to the DRA 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 DRA J-1 Visa Waiver Program.

   The DRA has established formal deadlines for these surveys. Both surveys should be returned to the DRA within 15 business days from the due date. If both surveys are not returned within the initial 15 business days, the DRA 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 DRA Compliance Guidelines, DRA will notify the appropriate agencies that compliance efforts were unsuccessful and recommend the taking of appropriate enforcement actions.

3. The DRA or an agent representing the DRA 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 DRA 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 DRA 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 Delta Regional Authority 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%

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 **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 in regard to the physician described above.

Please Return Form To:

Delta Regional Authority
Attention: Delta Doctors Program
236 Sharkey Avenue, Suite 400
Clarksdale, MS 38614

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 Delta Regional Authority 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 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 in regard to the medical facility listed above.

Please Return Form To:

Delta Regional Authority
Attention: Delta Doctors Program
236 Sharkey Avenue, Suite 400
Clarksdale, MS 38614

Delta Doctors Program

Physician Compliance Closing Survey

Note: Responses to the questions on this survey are strictly confidential. Only designated staff with the Delta Regional Authority 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 Delta Doctors 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 to 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 in regard to your overall experience with the Delta Doctors program:

Please Return Form to:

Delta Regional Authority
Attention: Delta Doctors Program
236 Sharkey Avenue, Suite 400
Clarksdale, MS 38614

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 CERTFIY THAT DOCTOR _____ PROVIDED DIRECT PARTIENT 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: _____

Delta Doctors Program

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/Parish: _____

**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: _____

☐ 1 Letter of Opinion from Legal Representatives

☐ 2 Form G-28

☐ 3 Physician Statement

☐ 4 Copy of Executed Contract

- ☐ Signed/dated by Physician/Employer
- ☐ 5 Year (NIW)
- ☐ 40 Hours per week or 160 hours per month of direct patient care
- ☐ Service to Medicaid/Meidcare/Indigent Patients
- ☐ Base Salary: _____
- ☐ Name of each worksite and address

☐ 5 Copies of Diplomas, licenses or applications for licenses

- ☐ State medical license or applicaton for license
- ☐ USMLE Scores

☐ 6 Complete passport (Verify all pages)

- ☐ I-129 Immigration Petition Approval Notice
- ☐ H-1B Approval Notices
- ☐ Copy of I-94

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 DRA checklist.

If documentation required in the checklist is omitted or does not meet the "Delta Doctors" 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 DRA queue for review. The DRA checklist should be completed and included in the J-1 visa waiver application to the Authority.

- Send the original application and one copy directly to Delta Regional Authority.
- Place the U.S. Department of State Case Number on all pages.
- Tab the application by the numbers listed below in the following order.

DRA 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 DRA underserved county or parish.
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 DRA underserved county or parish. 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

Regional Headquarters:
236 Sharkey Avenue, Suite 400 | Clarksdale, MS 38614
T 662.624.8600 | www.dra.gov