

## CHECKLIST for CONTINUATION of J-1 VISA SPONSORSHIP in ACGME-ACCREDITED CLINICAL TRAINING PROGRAMS

This checklist outlines the basic requirements to apply for J-1 visa sponsorship to participate in an Accreditation Council for Graduate Medical Education (ACGME)-accredited training program or a program leading toward certification offered by a member board of the American Board of Medical Specialties (ABMS). Identify all documentation with the applicant's USMLE®/ECFMG® number. Copied materials are acceptable; however, ECFMG reserves the right to examine the original document. Application submission requires coordination between the applicant and the Training Program Liaison (TPL) at the host institution. Submit all requirements in one package and allow four to six weeks for processing. Incomplete submissions will cause delay. ECFMG will communicate any deficiencies and/or requests for additional documentation through the TPL. Retain a copy of all materials.

- CONTRACT OR LETTER OF OFFER.** The contract or letter of offer must specify start and end dates of the training year, specialty and subspecialty of the training program/pathway, training level, and stipend. The applicant and an appropriate hospital official must sign the contract or letter of offer.
- FELLOWSHIP PROGRAM DESCRIPTION (if entering subspecialty training).** The fellowship description must follow attached guidelines.
- APPLICATION FORM FOR CONTINUATION OF J-1 VISA SPONSORSHIP.** The applicant must complete and sign Section A. The TPL must review Section A and complete and sign Section B.
- FORM I-644, SUPPLEMENTARY STATEMENT FOR GRADUATE MEDICAL TRAINEES (attached).** The exchange visitor physician must complete and sign Part 1; the program director or director of graduate medical education of the *most recent* (not proposed) host program must complete and sign Part 2 of the attached form.
- FORM I-94, ARRIVAL/DEPARTURE RECORD.** The Exchange Visitor must submit a photocopy of the front and back of the most recent Form I-94 documenting admission to the United States in J-1 status valid for "Duration of Status – D/S." Form I-94 may be attached to Form I-797, Notice of Action, issued by the U.S. Immigration and Naturalization Service or the U.S. Department of Homeland Security/Bureau of Citizenship and Immigration Services.
- \$200.00 ADMINISTRATIVE FEE (non-refundable).** Include USMLE/ECFMG number on a check or money order payable to ECFMG. For credit card payment, see OASIS on the ECFMG website ([www.ecfm.org](http://www.ecfm.org)).
- STATEMENT OF NEED (from the central office of the Ministry of Health in the applicant's country of most recent legal permanent residence).** See the *EVSP Reference Guide* on the ECFMG website for required format and wording. A certified, word-for-word English translation must accompany a non-English document.
- RETURN AIRBILL FOR EXPEDITED DELIVERY TO THE TPL (optional, but recommended).** If the application is approved, ECFMG will issue Form DS-2019, Certificate of Eligibility for Exchange Visitor (J-1) Status, to the TPL via first-class U.S. mail. ECFMG is not authorized to release the Form DS-2019 directly to the applicant. To expedite delivery, it is recommended that a *prepaid/preaddressed courier service airbill* be included with the application. Time constraints prevent EVSP staff from addressing airbills.

*Thank you for your interest in ECFMG's Exchange Visitor Sponsorship Program.  
For additional information, visit the ECFMG website at [www.ecfm.org](http://www.ecfm.org) or contact EVSP at 215-823-2121.*



**Application for Continuation of J-1 Visa Sponsorship in ACGME-Accredited Training Programs**

**SECTION B-To Be Completed by Training Program Liaison**  
*All information is REQUIRED. Please TYPE or PRINT.*

**SECTION A-To Be Completed by J-1 Exchange Visitor Physician**  
*All information is REQUIRED. Please TYPE or PRINT.*

6. Host Institution:  
ACGME Institution ID: \_\_\_\_\_  
Institution Name: \_\_\_\_\_  
Institution City, State: \_\_\_\_\_  
Medical School Affiliation: \_\_\_\_\_

7. ACGME-Accredited Training Program:  
ACGME Program ID: \_\_\_\_\_  
Specialty/Subspecialty: \_\_\_\_\_  
**Program Address.** Federal regulations require ECFMG to report the exchange visitor's site of training activity to the U.S. Government. Enter the physical street address:  
\_\_\_\_\_  
\_\_\_\_\_

USMLE®/ECFMG® Number: \_\_\_\_\_

*\*\*Enter all information EXACTLY as it appears on the passport.\*\**

1. Family Name: \_\_\_\_\_

2. Rest of Name: \_\_\_\_\_

3. Health and Accident Insurance: I confirm I will maintain required health and accident insurance for myself and all J-2 dependents while sponsored. If the insurance is not a part of my hospital training benefits package, then I will purchase private coverage.

\_\_\_\_\_  
*Name of Insurance Company*

4. Answer both of the following questions. Have you applied for either:  
a. U.S. Permanent Resident Status ("Green Card")? Y / N  
b. Waiver of the two-year home residence requirement? Y / N  
If yes to either or both, please elaborate on the status of the application(s).

5. Statement of Educational Objectives. Enter your specialty/subspecialty and duration of training.  
\_\_\_\_\_

8. Training Detail from Annual GME Contract:  
Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm/dd/yyyy) (mm/dd/yyyy)  
Training Level \_\_\_\_\_ Hospital Stipend \$ \_\_\_\_\_  
Other Funding Source and Amount, if applicable: \_\_\_\_\_  
*Submit documentation from the funding source confirming amount in U.S. dollars.*

**Exchange Visitor Certification:** I hereby certify that the information in this application is true and accurate to the best of my knowledge. I have read the EVSP *Reference Guide* and understand the obligations of J-1 sponsorship. I hereby authorize ECFMG to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any federal, state, or local governmental department or agency, to any hospital, or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information.

**X** \_\_\_\_\_  
Signature of Exchange Visitor Physician Date

E-Mail: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Residential Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Training Program Liaison Certification:** I hereby certify that the information I have provided is true and accurate to the best of my knowledge. I have read the EVSP *Reference Guide* and understand the obligations of hosting a J-1 exchange visitor physician.  
**X** \_\_\_\_\_  
Signature of Training Program Liaison (TPL) Date  
TPL Name: \_\_\_\_\_  
TPL Title: \_\_\_\_\_  
E-Mail: \_\_\_\_\_  
Tel: \_\_\_\_\_ Fax: \_\_\_\_\_  
TPL Mailing Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Application for J-2 Dependent Visa Sponsorship

The Educational Commission for Foreign Medical Graduates (ECFMG®) is authorized to sponsor the alien spouse and dependent unmarried minor children of the J-1 exchange visitor physician.

Please complete the following information and certify that you have obtained the required health and accident insurance for each J-2 dependent. Agencies of the U.S. Government require biographic details and spellings of all visa-related documents to match exactly. Attach a copy of the name page from each dependent's passport.

To Be Completed by Applicant J-1 Exchange Visitor Physician  
*All information is REQUIRED. Please TYPE or PRINT.*

**J-1 Exchange Visitor Physician**

1. USMLE®/ECFMG® Number: \_\_\_\_\_


2. Name: \_\_\_\_\_

**Federally Mandated Insurance Requirements**

Exchange Visitors are required to obtain insurance which provides: (1) medical benefits of \$50,000 per accident or illness, (2) a maximum \$500 deductible per accident or illness, (3) medical evacuation benefits of \$10,000, and (4) repatriation benefits of \$7,500.

ECFMG will purchase on behalf of Exchange Visitors and their dependents under ECFMG sponsorship medical evacuation and repatriation of remains insurance (numbers 3 and 4 listed above) at the prescribed levels as stipulated in the U.S. Code of Federal Regulations governing Exchange Visitor Programs. Exchange Visitors and their dependents are required to obtain health and accident insurance (numbers 1 and 2 listed above) at the prescribed levels of coverage. Exchange Visitors who willfully fail to comply with insurance regulations cannot be sponsored by ECFMG. (22 CFR § 62.14)

3. **Health and Accident Insurance:** I confirm I will maintain required health and accident insurance for myself and all J-2 dependents while sponsored. If the insurance is not a part of my hospital training benefits package, then I will purchase private coverage.

 \_\_\_\_\_  
Name of Insurance Company

**Exchange Visitor Certification:** I hereby certify that the information in this application is true and accurate to the best of my knowledge. I have attached passport copies.

**X** \_\_\_\_\_  
Signature of Exchange Visitor Physician Date

E-Mail: \_\_\_\_\_

Home Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Residential Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SPOUSE** *Verify details with the passport. Attach a copy of the passport name page.*

Family Name: \_\_\_\_\_

Rest of Name: \_\_\_\_\_

Gender: M / F Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (mm/dd/yyyy)

Place of Birth (City, Province, Country): \_\_\_\_\_

Country of Citizenship: *Dual citizens must specify which passport will be used when traveling.*

Country of Most Recent Legal Permanent Residence: \_\_\_\_\_

Spouse's USMLE/ECFMG Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
(if applicable)

**CHILD** *Verify details with the passport. Attach a copy of the passport name page.*

Family Name: \_\_\_\_\_

Rest of Name: \_\_\_\_\_

Gender: M / F Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (mm/dd/yyyy)

Place of Birth (City, Province, Country): \_\_\_\_\_

Country of Citizenship: *Dual citizens must specify which passport will be used when traveling.*

Country of Most Recent Legal Permanent Residence: \_\_\_\_\_

**CHILD** *Verify details with the passport. Attach a copy of the passport name page.*

Family Name: \_\_\_\_\_

Rest of Name: \_\_\_\_\_

Gender: M / F Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (mm/dd/yyyy)

Place of Birth (City, Province, Country): \_\_\_\_\_

Country of Citizenship: *Dual citizens must specify which passport will be used when traveling.*

Country of Most Recent Legal Permanent Residence: \_\_\_\_\_

**Additional children may be listed on a second form.**

ECFMG recommends that you include U.S.-born children to assure coverage of repatriation of remains and medical evacuation insurance.

**Submit this form and passport copies**  
With the Application for J-1 Visa Sponsorship  
**Or to**  
ECFMG - Exchange Visitor Sponsorship Program  
3624 Market Street, Philadelphia, PA 19104-2685 USA  
Tel (215) 823-2121 Fax (215) 386-9766

# FORM I-644: SUPPLEMENTARY STATEMENT FOR GRADUATE MEDICAL TRAINEES

U.S. Department of Justice  
Immigration and Naturalization Service

Supplementary Statement For  
Graduate Medical Trainees

OMB No. 1115-0108  
Approval expires 9/85

Affidavit for Exchange Visitor who seeks an extension  
of stay in order to complete a program of graduate  
medical education and training.

This form must be completed and submitted to the Immigration and Naturalization Service every year for each Foreign Exchange Visitor seeking an extension of stay in order to complete a program of graduate medical education and/or training. The collection of this information is required by Public Law 97-116.

## PART 1 To be Completed by Exchange Visitor

I certify that I am in good standing in a program of graduate medical education or training, under the exchange visitor program number indicated below, and that I will return to my country of nationality or last foreign residence upon completion or termination of my participation in the program. I also understand that I must reside in that country for at least two (2) years before I can qualify for an immigrant visa to the United States or for classification as an "H" or "L" nonimmigrant temporary worker.

My name is (please print) \_\_\_\_\_ ECFMG No: \_\_\_\_\_  
I am in the Exchange Visitor Program No: P-3-4510  
My field of study is \_\_\_\_\_  
My country of nationality is \_\_\_\_\_  
My country of last foreign residence is (OTHER THAN THE U.S.A.) \_\_\_\_\_  
I intend to work in the activity or medical specialty of \_\_\_\_\_  
My residential address is \_\_\_\_\_

I declare and certify under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on (Date) \_\_\_\_\_ Signature \_\_\_\_\_

## PART 2 To be Completed by Institutional Director of Graduate Medical Education or Training Program

I certify that the graduate medical student or trainee named in Part 1 is in good standing in the Exchange Visitor Program identified and that the information he or she provided is true and correct to the best of my knowledge.

Name of program director (please print) \_\_\_\_\_

Exact title of program director \_\_\_\_\_

Name of institution \_\_\_\_\_

Address of institution \_\_\_\_\_  
Street Name and Number City and State Zip

Executed on (Date) \_\_\_\_\_ Signature \_\_\_\_\_

**Form I-644 is an attestation of the exchange visitor physician's good standing in the Exchange Visitor Program as of his/her participation in his/her most recent host program. It must, therefore, be completed by the program director or the director of graduate medical education at the current, or most recent (not proposed) host institution.**

## Guidelines for Fellowship Program Description

One requirement for ECFMG sponsorship in subspecialty training is submission of a detailed program description. ECFMG developed the following as a guide for development of the program description to meet this sponsorship requirement. This outline is modeled after the format described in the American Medical Association's *Graduate Medical Education Directory* (the "Green Book"). Although there are no specific length requirements, program descriptions are typically 2-3 pages. All program descriptions must be prepared on official institutional letterhead, be signed by the program director, and *must* include the following information.

### A. Program Demographics

1. Name of Host Institution
2. Program Specialty/Subspecialty
3. Program Address (Mailing)
4. Program Address (Physical location, if different from mailing)
5. Program Phone Number
6. Program Fax Number
7. Program E-mail
8. Program Director
9. Alternate Program Contact

### B. Introduction

1. History. Identify how long the program has been in existence and include the number of individuals who have completed the training program since its inception.
2. Duration. Define an exact duration for the training program.
3. Prerequisite Training/Selection Criteria. Identify prerequisite training requirements and other selection criteria used in appointing candidate(s).
4. Goals and Objectives for Training. Define the educational purpose of the training program and intended goals of the training program.
5. Program Certifications. List any additional certifications or recognitions that the program may hold.

### C. Resources

1. Teaching Staff. List the teaching staff involved in providing the educational experience and their supervisory responsibilities over the participant(s). It is not necessary to send a faculty member's Curriculum Vitae (C.V.).
2. Facilities. List all training sites where rotations are conducted.

### D. Educational Program - Basic Curriculum

Describe the following elements of the training program:

1. Clinical and research components.
2. Participant's supervisory and patient care responsibilities.
3. Procedural requirements.
4. Didactic components.
5. If the program is more than twelve months in duration, please describe the progression in responsibilities by PGY level.

### E. Evaluation

Describe the formal evaluation process used to assess the educational performance of program participants.