CHECKLIST for CONTINUATION J-1 VISA SPONSORSHIP in RESEARCH SCHOLAR/NON-CLINICAL PROGRAMS OF OBSERVATION, CONSULTATION, TEACHING OR RESEARCH

This checklist outlines the basic requirements to apply for J-1 visa sponsorship to participate in a non-clinical training program of observation, consultation, teaching, or research. 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 submission 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 (to be renewed annually).

❒ **RESEARCH FELLOWSHIP PROGRAM DESCRIPTION.** The fellowship description must follow attached guidelines and specify the total program duration.

❒ **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.

❒ **PATIENT CONTACT CERTIFICATION STATEMENT.*** Official certification regarding level of patient contact (either incidental or no patient contact). See below.

❒ **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 U.S. 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.

❒ **$200.00 ECFMG ADMINISTRATIVE FEE (non-refundable).** Include applicant's full name and USMLE®/ECFMG® number (if applicable) on a check or money order payable to ECFMG.

❒ **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 *pre-paid/pre-addressed courier service airbill* be included with the application. Time constraints prevent EVSP staff from addressing airbills.

CERTIFICATION STATEMENT: *INCIDENTAL PATIENT CONTACT

Programs with patient contact incidental to the activities of observation, consultation, teaching, or research require a description of the fellowship program. In addition, the program must be affiliated with a United States medical school, which has been accredited by the Liaison Committee on Medical Education (LCME). The dean of the affiliated medical school or his/her designee is required to certify the following five-point statement. If the statement is certified by the dean's designee, a letter naming the designee is required from the dean.

1. *The program in which Dr. (applicant's name) will participate is predominantly involved with observation, consultation, teaching or research.*
2. *Any incidental patient contact involving the alien physician will be under the direct supervision of a physician who is a U.S. citizen or resident alien and who is licensed to practice medicine in the State of (state in which the training institution is located).*
3. *The alien physician will not be given final responsibility for the diagnosis and treatment of patients.*
4. *Any activities of the alien physician will conform fully with the State licensing requirements and regulations for medical and health care professionals in the State in which the alien physician is pursuing the program.*
5. *Any experience gained in this program will not be creditable towards any clinical requirements for medical specialty board certification.*

CERTIFICATION STATEMENT: *NO PATIENT CONTACT

Programs with no patient contact require a detailed description of the program outlining the overall curriculum. The program director/mentor of the research program is required to include the following certification statement.

> *"This certifies that the program in which Dr. (applicant's name) is to be engaged is solely for the purpose of observation, consultation, teaching or research, and that no element of patient care services is involved."*

Thank you for your interest in ECFMG's Exchange Visitor Sponsorship Program.
For additional information, visit the ECFMG website or contact EVSP at 215-823-2121.

ECFMG® | EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

3624 Market Street
Philadelphia PA 19104-2685 USA
215-823-2121 | 215-386-9766 Fax
www.ecfmg.org

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.

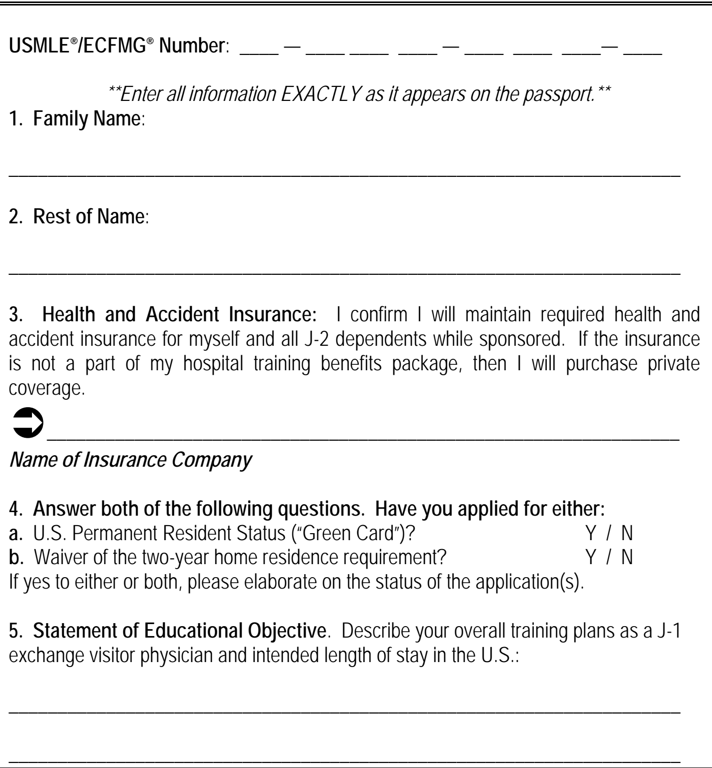
E. Evaluation

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

Application for Continuation of J-1 Visa Sponsorship in Non-Clinical Programs of Observation, Consultation, Teaching, or Research

SECTION A–To Be Completed by J-1 Exchange Visitor Physician

All information is REQUIRED. Please TYPE or PRINT.



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 Objective**. Describe your overall training plans as a J-1 exchange visitor physician and intended length of stay in the U.S.:

____

____

<u>Exchange Visitor Certification</u>: 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:

____

____

____

SECTION B–To Be Completed by Training Program Liaison

All information is REQUIRED. Please TYPE or PRINT.

6. **Host Institution:**

ACGME Institution ID: ___ ___ – ___ ___ ___ ___ (if applicable)

Institution Name:

____

Institution Address: ____

____

Medical School Affiliation: ____

7. **Training Program:**

Level of Patient Contact: ❒ No Patient Contact **OR** ❒ Incidental Patient Contact

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:

____

____

8. **Training Detail from Annual Contract:**

Start Date _____ / _____ / ________ End Date _____ / _____ / ________ (m/d/y)

Training Level ________________ Hospital Stipend $ __________________

Other Funding Source and Amount, if applicable: ________________________

Submit documentation from the funding source confirming amount in US Dollars.

<u>Training Program Liaison Certification</u>: 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:

____

____

____

USMLE®/ECFMG® Number: __ – __ __ __ – __ __ __ – __

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.

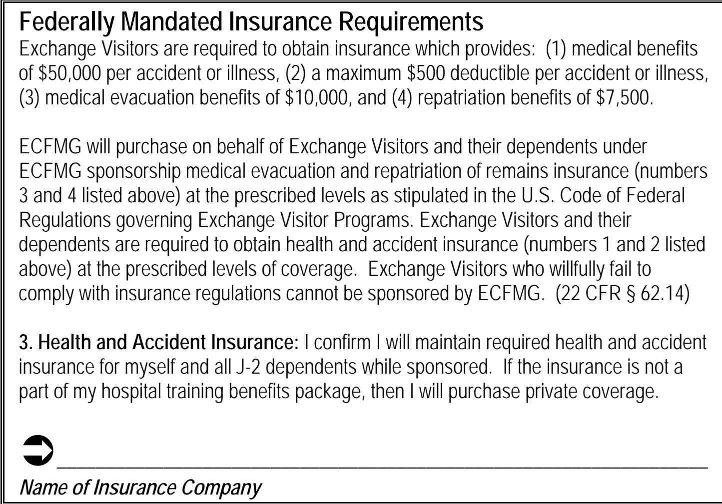
To Be Completed by Applicant J-1 Exchange Visitor Physician
All information is REQUIRED. Please TYPE or PRINT.

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 (11-1-82) **GPO 894-809**

Form I-644 is an attestation of the exchange visitor physician's good standing in the Exchange Visitor Program as of his 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.