



TO: J-1 Exchange Visitor Physicians
ECFMG Training Program Liaisons (TPLs)

FROM: Exchange Visitor Sponsorship Program (EVSP)

DATE: October 27, 2008

RE: DHS SEVIS Fee

Effective October 27, 2008, the non-refundable fee charged by the US Department of Homeland Security (DHS) to initial J-1 applicants will increase to \$180. The fee is also required for applicants changing status to J-1 and applicants seeking J-1 reinstatement. J-2 dependents are exempt from this fee. The US government collects this fee to cover its cost of implementing the Student and Exchange Visitor Information System (SEVIS) database for monitoring students and exchange visitors in the United States.

The SEVIS fee may be paid through the Internet at www.FMJfee.com by completing the electronic version of Form I-901 and submitting a credit card payment. Payment confirmation will be available immediately and should be printed for use as a receipt when applying for J-1 status. Additionally, a receipt will be sent by postal mail to the address indicated on the payment form.

The SEVIS fee must be paid in full before appearing for a visa interview. For those initial applicants who do not need a J-1 visa to enter the US, the fee must be paid in full before arriving at the US port-of-entry. Applicants will be expected to present a SEVIS fee payment receipt for the visa interview at the embassy, or at the US port-of-entry. If, for some reason, the printed or mailed receipt is not available to the applicant before the interview at the embassy or port-of entry, the applicant can appear for the interview as long as the SEVIS payment has been processed by DHS. For information on the SEVIS fee and detailed payment instructions, visit www.FMJfee.com.

Please note the DHS fee (\$180) is separate from and in addition to the ECFMG-EVSP administrative fee. The SEVIS fee must be paid directly to DHS.

Please contact the ECFMG-EVSP office with any questions regarding the SEVIS fee.

CHECKLIST for INITIAL 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, if applicable. 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 INITIAL 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.
- CURRENT CURRICULUM VITAE (C.V.).** The C.V. must detail the applicant's education and professional history to date.
- COPY OF MEDICAL SCHOOL DIPLOMA.** A certified, word-for-word English translation must accompany a non-English document.
- COPY OF PASSPORT NAME PAGE(S).** Submit a copy of the passport name page for the applicant and each dependent.
- FULL-FACE PASSPORT-SIZE PHOTOGRAPH.** Original photo required, no faxes or photocopies.
- \$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.
- ADDITIONAL DOCUMENTATION (if applicable)**
 - Copies of Form(s) IAP-66 and/or DS-2019 if the applicant has previously held J-1 visa status.
 - Proof of country of most recent legal permanent residence if this differs from country of citizenship.
 - Official documentation of funding source, terms, amount and US dollar equivalent if other than or in addition to hospital training stipend.
- 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.*

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 Initial J-1 Visa Sponsorship in Research Scholar/Non-Clinical Programs

SECTION A—To Be Completed by Applicant Physician
All information is REQUIRED. Please TYPE or PRINT.

USMLE®/ECFMG® Number: _____ (if applicable)
 Enter all information EXACTLY as it appears on the passport.

1. Family Name: _____

2. Rest of Name: _____

3. Gender: M / F 4. Date of Birth: ____/____/____ (mm/dd/yyyy)

5. Place of Birth (City, Province, Country):

6. Country of Citizenship:

Dual citizens must specify which passport will be used when travelling.

7. Country of Most Recent Legal Permanent Residence (LPR)*:

**Documentation of current LPR status is required if country of LPR differs from country of citizenship. The country of LPR determines the source of the Statement of Need.*

8. Have you ever been in the U.S. as a J-1 exchange visitor? Y / N
 If yes, submit copies of your previous Forms IAP-66/DS-2019 or a listing of your prior J-1 activities, including dates, activities, and location.

9. Are you currently in the United States? Y / N
 If yes, attach a copy of your current I-94 Arrival/Departure Record and answer:
 a. When did you enter the United States? ____/____/____ (mm/dd/yyyy)
 b. What is your current visa status? _____

10. 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

11. Statement of Educational Objectives. Enter your specialty/subspecialty and duration of training.

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. 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 of 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 Applicant Physician Date

E-Mail: _____

Home Tel: _____ Fax: _____

Residential Address:

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

12. Host Institution:
 ACGME Institution ID: _____ (if applicable)
 Institution Name: _____
 Institution Address: _____
 Medical School Affiliation: _____

13. 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:

14. Training Detail from Annual 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 US Dollars.

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