SOUTHEAST CRESCENT
REGIONAL COMMISSION

J-1 Visa Waiver Program
Compliance Guidelines

The Southeast Crescent Regional Commission 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 15th and December 15th of each year. The surveys will be completed and returned separately to the Commission 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 SCRC J-1 Visa Waiver Program.

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

3. The SCRC or an agent representing the SCRC 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 SCRC will immediately notify the appropriate agencies and recommend the taking of appropriate enforcement actions.

SOUTHEAST CRESCENT
REGIONAL COMMISSION

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 SCRC 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

SOUTHEAST CRESCENT
REGIONAL COMMISSION

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 Southeast Crescent Regional Commission 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 regarding the physician described above.

SOUTHEAST CRESCENT
REGIONAL COMMISSION

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 Southeast Crescent Regional Commission 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 regarding the medical facility listed above.

SOUTHEAST CRESCENT
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J-1 Visa Waiver Program Physician
Compliance Closing Survey

Note: Responses to the questions on this survey are strictly confidential. Only designated staff with the Commission 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 J-1 Visa Waiver 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 regarding your overall experience with the J-1 Visa Waiver program:

SOUTHEAST CRESCENT
REGIONAL COMMISSION

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: _____

SOUTHEAST CRESCENT
REGIONAL COMMISSION

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: _____

**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/Medicare/Indigent Patients
- ☐ Base Salary: _____
- ☐ Name of each worksite and address

☐ 5 Copies of Diplomas, licenses or applications for licenses

- ☐ State medical license or application 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 SCRC checklist.

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

- Send the one application to 15 Lake Drive, Wilson, AR 72395 with a copy of the check and one copy directly to the Southeast Crescent Regional Commission with the check attached
- Place the U.S. Department of State Case Number on all pages.
- Tab the application by the numbers listed below in the following order.

SCRC 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 SCRC underserved county.
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 SCRC underserved county. 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