

**J-1 Conrad Waiver Case Initiation**

We need the following information and/or documentation to start the J-1 waiver process with the State of Maryland.

1. Contact details for the Beneficiary’s supervisor:
   * Name:
   * Title:
   * Street Address:
   * Phone number:
   * Email address:
2. Contact details for the person (e.g., supervisor, department chair, etc.) who will sign the memo (letter) explaining the work the Beneficiary does:
   * Name:
   * Title:
   * Street Address:
   * Phone number:
   * Email address:
3. Full name and Tax ID number of proposed sponsoring employer if not UMB (52-6002033)
4. Copy of the official position description for the position being offered to the Beneficiary. (*If a promotion is in the offing, please advise us immediately as this will significantly affect case processing*.)
5. List all advertisements run to seek suitable US workers to fill the Beneficiary’s position in the past year to eighteen months. (Please also send us copies of all the ads. We will need to demonstrate at least six months of recruitment within a one year period. We may need to request additional or different ads, depending on where and when the ads were run.)
6. Describe how many applicants have applied for the position being filled by the Beneficiary. Explain why each applicant was not qualified for the position.
7. Salary being offered to the Beneficiary
8. The wage range applicable to the Beneficiary’s position (if there is no specific wage range for this position, please let us know what is the most and least that is paid to someone in this position)
9. Please confirm whether the Beneficiary received government funding to support his or her J residency program.
10. Provide a list of ALL intended work sites for the full three years of anticipated work. This would include ALL work sites, for clinical, administrative, or other duties. Provide additional sites, if any, in an attachment.

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| Facility Name | Street Address | City, State, Zip Code |
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1. Describe why the employing entity requires the services of the Beneficiary.
2. Explain how this physician can address a need within the state of Maryland, generally.  *(The more specifics provided, the better. For example, it is helpful to highlight the fact that a physician is one of two specialists in a particular field known to be in the State.)*
3. Complete the Site Application for EACH site of intended employment that is located within this document. *(Please note that this form is quite detailed and requires considerable information about providers and patients at EACH site of intended employment. It may take some time to prepare.)*
4. For EACH site of intended employment, please provide the following:
5. Background information about the practice.
6. A copy of the site’s brochure or marketing material if available.
7. A copy of the site’s Sliding Fee Scale and Sliding Fee Scale Policy for that site.
8. A copy of the posted public notice at the practice site, which indicates a Sliding Fee Scale, is in effect.
9. Please provide a draft contract of employment that meets the requirements listed below. We will review the contract to ensure that it meets the Maryland requirements.

* The contract must NOT be in “letter” form;
* The contract must state that the J-1 physician will practice a minimum of 40 hours per week (at least 32 of the required 40 hours must be in direct patient care), not including hospital rounds, travel, and on-call time, for not less or more than the required three (3) years, at the approved practice site listed on the site application(s).
* The contract must list all work-sites (name **and** address) of ALL medical practice sites *(including hospitals)* where the J-1 physician will be working. If the J-1 physician will work at more than one site, include the days and hours of practice at each site and a breakdown in the amount of time the physician will practice at each site.
* The contract must stipulate all employment in which the J-1 physician will engage; no moonlighting is allowed. The contract should also specify any employment expectations regarding hours worked vs. hospital rounds and/or on-call requirements as well as travel time.
* The contract must require the physician to start to work within 90 days of the grant of the waiver and to remain working for three years in the designated area.
* The contract may NOT include a non-compete clause or restrictive covenants preventing or discouraging the J-1 physician from continuing to practice in the service area of former employment once the sponsored employment has ended.

Maryland J-1 Visa Waiver Program

**SITE APPLICATION -- REQUIRED FOR EACH SITE OF INTENDED EMPLOYMENT**

1. Name of Practice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Street Address w/zip code *and County* where the Physician **will practice***:*

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3. Please check applicable: This site is a: FQHC  MQHC  Private Practice  Other

4. Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext.\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person’s Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Name of Physician applying for J-1 Visa Waiver \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Is the Physician currently working at the Site? \_\_\_\_\_\_

7. How many hours of the week will the physician be working at the site? \_\_\_\_\_\_

8. Number of Full-time Equivalent Providers at the Site:

Family Practice: \_\_\_\_\_\_\_ Internal Medicine: \_\_\_\_\_\_

Pediatrician: \_\_\_\_\_\_\_ OB/GYN: \_\_\_\_\_\_

Nurse Practitioner:\_\_\_\_\_\_\_ Geriatrics: \_\_\_\_\_\_

Physician Assistant: \_\_\_\_\_\_\_ Psychiatrist: \_\_\_\_\_\_

Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. If applicable, number of current J-1 Visa Waiver physicians at this site? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. How long has the position been vacant? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

11. Does the Practice reduce fees for low-income persons who have limited ability to pay? \_\_\_\_\_\_\_\_

12. What **specific need** will the Physician meet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. How will this Physician improve the Practice and the community? (*Use additional sheets if necessary*.)

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14. Please list the number of persons served by **The practice site where the J-1 Physician will practice** for the most recent year for which complete data are available:

**Number Percentage**

Medicaid \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Medicare \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Commercial Insurance \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Uninsured Self-Pay \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Sliding Fee \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

(100% Self Pay, Above 200% Poverty)

Other \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

(Underinsured or No Insurance,

Below 200% Poverty)

Total \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Additional Comments

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Maryland J-1 Visa Waiver Program

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4. Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physician’s Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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12. What **specific need** will the Physician meet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Maryland J-1 Visa Waiver Program

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Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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11. Does the Practice reduce fees for low-income persons who have limited ability to pay? \_\_\_\_\_\_\_\_

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**Number Percentage**

Medicaid \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Medicare \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Commercial Insurance \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Uninsured Self-Pay \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Sliding Fee \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

(100% Self Pay, Above 200% Poverty)

Other \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

(Underinsured or No Insurance,

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Total \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Additional Comments

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