



Application for Continuation of J-1 Visa Sponsorship to Complete an ABMS Member Board Examination

Exchange visitor physicians may apply for a J-1 visa sponsorship extension following completion of sponsored training if they are registered to sit for an examination administered by a member board of the American Board of Medical Specialties (ABMS). If approved, sponsorship to sit for an examination extends only from the expiration date of the most recent training Form IAP-66 or DS-2019 to the last day of the month in which the exam is given – not to exceed a six-month period. Examinations which are not administered by an ABMS member board do not qualify for J-1 visa sponsorship extension. Note that there is no training or employment authorization during an extension to sit for a board examination.

CHECKLIST. This checklist outlines the basic requirements for this application. Identify all documentation with your USMLE/ECFMG number. Copied materials are acceptable; however, ECFMG reserves the right to examine the original document. Submit all requirements in one package and allow four to six weeks for processing. Incomplete submissions will cause delay. Retain a copy of all materials.

- APPLICATION FORM. The exchange visitor physician must complete and sign this form.
DOCUMENTATION OF REGISTRATION FOR EXAMINATION. The exchange visitor physician must submit proof from the specialty board of exam registration (or initiation of registration).
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 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.
DOCUMENTATION OF FUNDING. Because there is no training or employment authorization during a sponsorship extension to sit for a board examination, an exchange visitor physician must document that (s)he has adequate personal funds available to support him/herself and dependents. Minimum funding levels are \$1200 per month for the J-1 physician, \$400 per month for the J-2 spouse, and \$200 per month per child (any status). Submit a letter from a bank official or a copy of bank statement(s) confirming the funding amount entered in item 6. Foreign currency must also include U.S. dollar equivalent.
\$250 ADMINISTRATIVE FEE (non-refundable). To pay on-line, access OASIS on the ECFMG website (www.ecfm.org). If you pay by check or money order, make the check or money order payable to ECFMG. Include your USMLE/ECFMG Identification Number, if applicable, on the check or money order.

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

USMLE/ECFMG Number: \_\_\_\_\_

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. After I complete my contracted training, I will arrange continued insurance coverage. Coverage options may include purchase through COBRA or other private purchase of the requisite insurance.

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. \_\_\_\_\_

6. Personal Funds: \$ \_\_\_\_\_

7. Examination Detail. I am registered or in the process of registering for the following examination(s):
Specialty/Subspecialty: \_\_\_\_\_ of the
American Board of \_\_\_\_\_ on
Exam Date(s) \_\_\_\_\_ (mm/dd/yyyy)

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: \_\_\_\_\_



# 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.**