

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.
- \$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.
- 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.*



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

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

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

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

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 research scholar and intended length of stay in the U.S.:

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:

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 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 Exchange Visitor Physician Date

E-Mail: _____
(Must maintain active e-mail on ECFMG's OASIS.)

Tel: _____ Fax: _____

Residential 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.

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

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 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.

Guidelines for Research Program Description

One requirement for ECFMG sponsorship as a Non-Clinical Research Scholar is submission of a detailed research program description. ECFMG created the following as a guide for developing the program description to meet this sponsorship requirement. Although there is no specific length requirement, research program descriptions that follow ECFMG guidelines are typically 2-3 pages long. All research 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 Research Specialty and Research Study
2. Name of Host Institution
3. Research Program Specialty/Subspecialty
4. Research Program Address (Mailing)
5. Research Program Address (Physical location, if different from mailing)
6. Research Program Phone Number
7. Research Program Fax Number
8. Research Program E-mail
9. Research Program Director
10. Alternate Research Program Contact

B. Introduction

1. History - identify how long the Research Program at the Research Institute has been in existence.
2. Duration - identify the proposed duration that will be needed for the research project(s).
3. Prerequisite selection criteria - identify prerequisite education, prior training and/or research experience requirements and other selection criteria used in appointing researchers.
4. Goals and objectives for the research project(s) - define the ultimate goals of the research project(s) as well as the proposed goal for the individual researcher.
5. Program certifications - list any additional certifications or recognitions that the program may hold.

C. Resources

1. Teaching and permanent research staff and faculty - list the supervisory staff involved in providing the research 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 facilities where the research projects are conducted.

D. Research Program

Describe the following elements of the Research Program:

1. Research and didactic components and the specific proposed research goals and plans for the J-1 Research Scholar applicant.
2. Identify if the Research Scholar is involved in on-going and continuing research.
3. Participant's supervisory responsibilities.
4. Patient contact: No Patient Contact vs. Incidental Patient Contact; if proposed research program has Incidental Patient Contact, outline the exact duties.
5. Procedural requirements - detail the procedures that the visiting researcher will be expected to follow.
6. If the proposed research is more than 12 months in duration, please explain each year's duties and proposed research projects of the participants.

E. Research Goals/Evaluation

Describe the formal evaluation process, if any, used to assess the research performance of the researchers.