Conrad 30 J-1 Visa Waiver Program Employer Form

Instructions: **This is a fillable form and must be downloaded and completed electronically.** Completion of this form is a required component of the application for a physician to be considered for the Conrad J-1 Visa Waiver Program. This form collects information about the employer and practice site(s) where the physician will be fulfilling a service obligation.

An **authorized representative** of the agency/organization for which the physician seeks employment is responsible for completing this form. To complete the form, follow these steps:

1. Download the fillable form
2. Complete the form
3. Print the form
4. Notarize the form
5. Return the signed and notarized form to the J-1 visa waiver requester

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If you did have any questions, please contact:

Cristie Duric
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515-229-3913

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515-281-6765

Employer Information

This section gathers information about the employer as well as information about the practice sites at which the physician will be providing services as part of the J-1 Visa Waiver Program. The information provided in this form must match the information in the employer contract and the letter of request submitted by the employer or legal counsel on behalf of the physician.

Application Type:

Employer Legal Name:

Address:

City, State, Zip:

County:

Legal Business Structure: **Years of Operation:**

Business Type: **If other business type, specify:**

If the employer site is also a practice site where the candidate will be fulfilling the service obligation, provide the following information:

Shortage Designation Type:

Designation ID: **Designation Name:**

Designation Discipline: **FTE:**

Point of Contact Information

Point of contact should be an authorized representative of the employer.

Authorized Representative Name:

Business Name (if different from Employer):

Address:

City, State, Zip:

Phone: **Fax:**

Email:

Physician Information

Physician Name:

Physician Discipline:

Specialty Discipline (if applicable):

Practice Site Information

Provide information about each practice site (in addition to the employer site if considered a practice site) that the candidate will be providing services. If the practice site is federally designated as a HPSA, MUA, or MUP, further information is required and can be found at https://data.hrsa.gov/tools/shortage-area/hpsa-find.

All practice sites *must* be located in Iowa.

Practice Site 1 Legal Name: **FTE:**

Address:

City, State, Zip:

Practice Site Type:

Shortage Designation Type:

Complete designation information below if Shortage Designation Type is a HPSA, MUA, or MUP.

Designation ID: **Designation Name:**

Designation Discipline:

Practice Site 2 Legal Name: FTE:

Total Calculated FTE (must be < =1.0): 0.00

Address:

City, State, Zip:

Practice Site Type:

Shortage Designation Type:

Complete designation information below if Shortage Designation Type is a HPSA, MUA, or MUP.

Designation ID: **Designation Name:**

Designation Discipline:

Practice Site 3 Legal Name: **FTE:**

Address:

City, State, Zip:

Practice Site Type:

Shortage Designation Type:

Complete designation information below if Shortage Designation Type is a HPSA, MUA, or MUP.

Designation ID: **Designation Name:**

Designation Discipline:

Practice Site 4 Legal Name: **FTE:**

Address:

City, State, Zip:

Practice Site Type:

Shortage Designation Type:

Complete designation information below if Shortage Designation Type is a HPSA, MUA, or MUP.

Designation ID: **Designation Name:**

Designation Discipline:

Practice Site 5 Legal Name: **FTE:**

Total Calculated FTE (must be < =1.0): 0.00

Address:

City, State, Zip:

Practice Site Type:

Shortage Designation Type:

Complete designation information below if Shortage Designation Type is a HPSA, MUA, or MUP.

Designation ID: **Designation Name:**

Designation Discipline:

Practice Site 6 Legal Name: **FTE:**

Address:

City, State, Zip:

Practice Site Type:

Shortage Designation Type:

Complete designation information below if Shortage Designation Type is a HPSA, MUA, or MUP.

Designation ID: **Designation Name:**

Designation Discipline:

Practice Site 7 Legal Name: **FTE:**

Address:

City, State, Zip:

Practice Site Type:

Shortage Designation Type:

Complete designation information below if Shortage Designation Type is a HPSA, MUA, or MUP.

Designation ID: **Designation Name:**

Designation Discipline:

Practice Site 8 Legal Name: **FTE:**

Total Calculated FTE (must be < =1.0): 0.00

Address:

City, State, Zip:

Practice Site Type:

Shortage Designation Type:

Complete designation information below if Shortage Designation Type is a HPSA, MUA, or MUP.

Designation ID: **Designation Name:**

Designation Discipline:

Practice Site 9 Legal Name: **FTE:**

Address:

City, State, Zip:

Practice Site Type:

Shortage Designation Type:

Complete designation information below if Shortage Designation Type is a HPSA, MUA, or MUP.

Designation ID: **Designation Name:**

Designation Discipline:

Practice Site 10 Legal Name: **FTE:**

Address:

City, State, Zip:

Practice Site Type:

Shortage Designation Type:

Complete designation information below if Shortage Designation Type is a HPSA, MUA, or MUP.

Designation ID: **Designation Name:**

Designation Discipline:

Total Calculated FTE (must be < =1.0): 0.00

Recruitment Efforts

The employer must show that recruitment was conducted for a minimum of 6 months for the specific position being filled by the J-1 visa waiver requester.

Pertaining to the specific position being filled by the physician requesting a J-1 visa waiver, how long has the position been vacant?

What was the specific method or methods used to recruit for the position being filled by the physician requesting a J-1 visa waiver?

- ☐ **Online job board**
- ☐ **Print media**
- ☐ **Word of mouth**
- ☐ **Social media**
- ☐ **Job fair**
- ☐ **Recruitment Firm**
- ☐ **Other:**

Provide more specific information about each recruitment method selected. (i.e. specific job boards, what social media platforms, or what type of print materials were used).

How many inquiries were U.S.-born physicians?

How many candidates were identified as a result of the recruitment efforts for the position being filled by the physician requesting a J-1 visa waiver?

How many interviews were conducted as a result of the recruitment efforts for the position being filled by the physician requesting a J-1 visa waiver?

How many offers were made as a result of the recruitment efforts for the position being filled by the physician requesting a J-1 visa waiver?

How many offers were to U.S.-born physicians?

If an offer(s) was made, what was the reason(s) the position was not filled?

Employer Acknowledgments (Print form and initial to acknowledge each statement)

___	Employer holds harmless the State of Iowa, the Iowa Department of Public Health, any and all State of Iowa employees and agents from any action or lack of action made in connection with this application.

Total Calculated FTE (must be < =1.0): 0.00

___	Employer acknowledges that once this application is submitted to the Iowa Department of Public Health, it will be processed according to the date submitted and cannot be held until a future date.
___	Employer acknowledges that, should the physician receive a J-1 visa waiver, service must commence not later than ninety (90) days after notification of approval by both the U.S. Citizenship and Immigration Services (USCIS) and the U.S. Department of Labor, and shall continue for a period of at least three (3) years.
___	Employer acknowledges that, should the physician receive a J-1 visa waiver, the physician is required to provide primary care services to all individuals regardless of ability to pay, including Medicaid- and Medicare-eligible patients, as well as indigent and uninsured patients.
___	Employer acknowledges that services must be provided for a minimum 3-year term and forty (40) hours per week.
___	Employer acknowledges that, should the physician receive a waiver, all J-1 visa waiver requirements must be included in all applicable employment agreements and amendments.
___	Employer acknowledges that, should the physician receive a J-1 visa waiver, any practice site(s) changes must be approved by the USCIS and notification must be provided to the Department.
___	Employer acknowledges the requirement to submit required documentation to the Iowa Department of Public Health for the duration of the service obligation.

By signing this document, you acknowledge that you are an authorized representative of the employer identified in this form and that you are requesting the Iowa Department of Public Health act as an interested government agency for the purpose of requesting a waiver of the foreign residency requirement of the J-1 Visa, and that the information provided is truthful and accurate to the best of your ability.

Signature:

_____

Print Name:

Title:

Date:

Verification upon Oath or Affirmation

State _____
County of _____

Signed and sworn to (or affirmed) before me on this _____ by _____
[Date] [Name(s) of individual(s)]

_____
[Signature of notarial officer]

[Stamp]

_____
[Title of office]
My commission expires: _____