

Kim Reynolds, Governor

Adam Gregg, Lt. Governor

Conrad 30 J-1 Visa Waiver Program Physician Form

Instructions: <u>This is a fillable form and must be downloaded and completed electronically.</u> 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.

To complete the form, follow these steps:

- 1. Answer all of the questions to the best of your ability
- 2. Print the form
- 3. Notarize the form
- 4. Submit notarized form with J-1 Visa Waiver Program Application

If you did have any questions, please contact:

Cristie Duric cristie.duric@idph.iowa.gov 515-229-3913 Kevin Wooddell kevin.wooddell@idph.iowa.gov 515-281-6765

Physician Information

Legal Name (Last, First, MI):

Street Address:

City, State, Zipcode:

Email:

NPI:

Phone:

Country of Birth:

Country of Last Residence:

Discipline:

Specialty Discipline, if applicable:

Physician Acknowledgements (Print form and initial to acknowledge each statement)	
	Physician understands the conditions and requirements of the Conrad 30 Visa Waiver Program.
	Physician 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.
_	Physician acknowledges that Conrad 30 J-1 visa waivers are approved and issued by the U.S. Citizenship and Immigration Services.
	Physician does not have pending, nor will physician submit another application while this application is pending, to any U.S. Government department or agency equivalent to act on physician's behalf in any matter relating to a waiver of physician's two-year home residence requirement.

	Physician acknowledges that submitted applications will be processed according to the date submitted and cannot be held until a future date.
	Physician acknowledges that 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.
_	Physician 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.
	Physician acknowledges that services must be provided for a minimum 3-year term and forty (40) hours per week.
	Physician acknowledges that the requirements for a waiver are 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.
	Physician acknowledges that J-1 visa waiver requirements must be included in all applicable employment agreements and amendments.
	Physician acknowledges that the Iowa Department of Public Health will notify U.S. Citizenship and Immigration Services for failure to comply with the terms and conditions of the J-1 Visa Waiver Program.

By signing this document, you agree with the conditions and requirements of the J-1 Visa Waiver Program and that the information provided is truthful and accurate to the best of your ability.

Signature:

 Name:

 Title:

 Date:

 Verification upon Oath or Affirmation

 State

 County of

 Signed and sworn to (or affirmed) before me on this

 [Date]

 [Name(s) of individual(s)]

 [Signature of notarial officer]

 [Stamp]

 [Title of office]

 My commission expires: