



## MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION

The Mississippi Office of Rural Health and Primary Care (PCO) has been designated to serve as the State Contact and clearinghouse for the Mississippi Conrad State 30 J-1 Visa Waiver Program. The PCO will administer the program in a fair and consistent manner, as well as provide technical assistance to all entities interested in developing a Mississippi Conrad State 30 J-1 Visa Waiver Program Application for placement of a foreign-trained J-1 Visa physician.

### THE FOLLOWING IS IMPORTANT INFORMATION PERTAINING TO THE MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER APPLICATION PROCESS:

- Health care facilities/sites interested in employing J-1 Visa Waiver physicians must submit the Mississippi Conrad State 30 J-1 Visa Waiver Program Application.
- Applicants must submit a copy of the published legal notice announcing intent to apply for the Conrad State 30 J-1 Visa waiver for a physician (see respective application section or application for instructions).
- The PCO will provide applicants information on currently designated health professional shortage areas (HPSAs) for primary medical care or mental health (if requested).
- Medical facilities located in those counties which are a part of the Appalachian Regional Commission (ARC) are not eligible to recruit primary care J-1 Visa physicians through the Conrad State 30 J-1 Visa Waiver Program. Primary Care includes family practice, general practice, general pediatrics, obstetrics, and general internal medicine. The ARC J-1 Visa Waiver Program must be used to request waivers for facilities located in those counties which are a part of the Appalachian Regional Commission (ARC) who are interested in primary care J-1 physicians. However, facilities located in ARC counties can recruit psychiatrists and specialists under this Conrad State 30 J-1 Visa Waiver Program.
- A non-refundable processing fee of \$2,000.00 is required to process a Mississippi Conrad State 30 J-1 Visa Waiver application. A check or money order from the sponsoring facility should be payable to the Mississippi State Department of Health and submitted with the completed Conrad State 30 J-1 Visa Waiver application. No complete Conrad State 30 J-1 Visa Waiver application will be processed without payment of the processing fee.
- The review cycle should be completed within 180 days.
- The U.S. Department of State requires that the J-1 Visa Waiver Physician Data Sheet be submitted to the appropriate address contained in the Department's policies, along with the user processing fee identified on the U.S. Department of State website. For this information and all current requirements, please visit the U.S. Department of State website.
- Submission of an application to the Mississippi State Department of Health does not guarantee that the Mississippi State Department of Health will recommend approval of the application to the federal level. Applicants will be notified in writing of applications that are not recommended for approval.
- It is important to distinguish between recommendation of approval by the Mississippi State Department of Health and actual approval of the application for a J-1 Visa Waiver. The Mississippi State Department of Health will review complete applications and, if appropriate, submit an approval recommendation to the federal level. A recommendation by MSDH does not guarantee that the application will be approved by United States citizen and immigration services (USCIS). The Mississippi State Department of Health cannot estimate the length of time the USCIS will require to make its decision. USCIS approval is required to work legally in the United States.

Applicants may check the status of their application at the federal level by contacting the United States Department of State.



MISSISSIPPI STATE DEPARTMENT OF HEALTH

**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION**  
**United States Department of State Information**

Please visit the United States Department of State website for their specific requirements related to applying for a J-1 Visa Waiver.



**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION**  
**Application Information**

Please submit one (1) original and one (1) hard copy of the completed application to the Mississippi Office of Rural Health and Primary Care (MORHPC) via postal address.

Please include a table of contents and separate each section by alphabetical dividers. Please do not use staples, binders, metal clamps, two-sided copies, and/or pages smaller than 8.5 x 11 inches. Please use a rubber band to separate each copy. The USIA File Number must be included on all pages.

The application should be mailed to the following address:

**Judy Newton, Director**  
**Office of Rural Health and Primary Care**  
**Mississippi State Department of Health**  
**Post Office Box 1700**  
**Jackson, Mississippi 39215-1700**

If you have any questions, please email [physicianvisawaiver@msdh.ms.gov](mailto:physicianvisawaiver@msdh.ms.gov)

**Submission of an application to the Mississippi State Department of Health (MSDH) does not guarantee that the MSDH will recommend approval of the application to the federal level.**

**It is also important to distinguish between a recommendation by the MSDH and actual approval of the application for a J-1 Visa Waiver. The MSDH will if appropriate, submit an approval recommendation to the federal level. A recommendation by the MSDH does not guarantee that the application will be approved by the United States Citizen and Immigration Services (USCIS).**



**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION  
Application Exhibit Section**

**Please submit the following information in the order listed for the J-1 Visa Waiver Program**

Exhibit 1.	Sections A through J of the Conrad State 30 J-1 Visa Waiver Application
Exhibit 2.	Letter from Employer
Exhibit 3.	Copy of notarized, dated, executed tentative employment contract
Exhibit 4.	Legible copy of applicant’s <b>DS-2019/IAP-66 Forms</b> , covering every period the applicant was in J-1 Status. Must be submitted in chronological order (from entry to present). Foreign trained provider must not have been “out of status” for more than 180 days since receiving a visa.
Exhibit 5.	Copies (front and back) of <b>I-94</b> Entry and Departure Cards of applying physician.
Exhibit 6.	Copy of the applying physician’s Curriculum Vitae (CV)
Exhibit 7.	<b>Form GS-28</b> or Notice of Entry of Appearance as Attorney Authorized Representative
Exhibit 8.	<b>Form DS-3035</b> J-1 Visa Waiver Recommendation Application Supplementary Applicant Information Pages
Exhibit 9.	Statement of Reason
Exhibit 10.	Third Party Barcode Page
Exhibit 11.	Waiver Division Barcode Page
Exhibit 12.	Copy of applying physician’s Educational Commission for Foreign Medical Graduates Certificate.
Exhibit 13.	Proof of USMLE Step 1:_____ Step 2:_____ Step 3:_____ (List actual score) Please enter description of the applicant’s discipline and specialty:
Exhibit 14.	Medical Degrees If applicant is still in a residency program, please indicate the anticipated completion date:
Exhibit 15.	Copy of applying physician’s Mississippi Medical License or documentation that application in process.
Exhibit 16.	Documentation of applying physician’s Board Certification or Board eligibility status.
Exhibit 17.	Copy of applying physician’s passport
Exhibit 18.	A copy of the applying physician’s completed Waiver Review Application US Department of State Data Sheet.



**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION  
SECTION A – Cover Letter**

**Please submit a cover letter to the Mississippi Office of Rural Health and Primary Care. The cover letter should be on the employer’s official letterhead and must include the information below in the order listed.**

Date

MORHPC Director’s Name  
Mississippi Office of Rural Health and Primary Care  
Mississippi State Department of Health  
Post Office Box 1700  
Jackson, MS 39215-1700

Dear Director:

1. A statement indicating that the sponsoring medical facility (indicate type of facility, i.e., hospital, FQHC, clinic) is interested in applying for a J-1 Visa waiver through the Conrad State 30 J-1 Visa Waiver Program for a [identify specific medical discipline] physician and is requesting that the Mississippi State Department of Health submit a waiver application to the United States Department of State.
2. The name of the sponsoring medical facility, its complete street address (including 9-digit zip code, and county location).
3. The name and location (complete address, 9-digit zip code, and county) of the practice site(s) where the applying J-1 Visa physician will complete the three-year full-time service obligation (if different from #2 above).
4. The name of the Health Professional Shortage Area (HPSA) to be served.
5. The name of the applying J-1 Visa physician, country of last permanent residence, and information on qualifications and duties.
6. A paragraph describing why the waiver is in the public interest.
7. A statement that the facility is offering the applying J-1 Visa physician at a minimum, a three-year employment contract to work 40 hours per week as a primary care physician, psychiatrist, or medical specialist to provide health care services for residents of [name the HPSA(s)].



**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION  
SECTION B – Sponsoring Medical Facility Information Sheet**

Name of Sponsoring Medical Facility \_\_\_\_\_

Street Address \_\_\_\_\_

P.O. Box \_\_\_\_\_

City \_\_\_\_\_ 9-Digit Zip Code \_\_\_\_\_

County \_\_\_\_\_

Phone Number \_\_\_\_\_

Name of Chief Executive Official \_\_\_\_\_

Contact Person for Application \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

**Nature of the primary care services to be provided full time by applying J-1 Visa Physician:**

- Family Practice                       General Practice                       General Internal Medicine
- Pediatrics                                       Psychiatry                                       Obstetrics and Gynecology
- Specialist (specify) \_\_\_\_\_

**Please Check:**     Private Not-For-Profit     Private For-Profit     Public Not-For-Profit

**Type of Practice (select all that apply):**

- Federally Qualified Health Center                       Rural Health Clinic
- Critical Access Hospital                                       Outpatient/Ambulatory
- National Health Service Corps Site                       Public Health Department
- Federally Qualified Health Center Look-Alike                       Community Mental Health Agency
- Free Clinic
- Other (specify) \_\_\_\_\_

Medicaid # \_\_\_\_\_ Medicare # \_\_\_\_\_



**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION  
SECTION C – Practice Site Information Sheet**

**Please label this section C. A separate sheet must be completed for each Practice Site (make copies if needed).**

Name of Practice Site \_\_\_\_\_

Street Address \_\_\_\_\_

PO Box \_\_\_\_\_

City \_\_\_\_\_ 9-Digit Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ County \_\_\_\_\_

1. How long has this site been operational? \_\_\_\_\_ (Years)
2. If application is for a primary care physician, is this practice site located in a federally designated primary care Health Professional Shortage Area (HPSA)?  Yes  No
3. If application is for a psychiatrist, is this practice site located in a federally designated Mental Health Professional Shortage Area (HPSA)?  Yes  No
4. Is there a Hospital/Provider Referral Arrangement for this physician?  Yes  No
5. Is there a Hospital Admission Agreement for this physician?  Yes  No

**Provide data for public service rendered at this practice site for previous calendar year**

Patient breakdown by primary payer source for this reporting period (total should equal 100%):

- a. Total Number of Unduplicated Patients \_\_\_\_\_%
- b. Medicare \_\_\_\_\_%
- c. Medicaid \_\_\_\_\_%
- d. SCHIP Patients \_\_\_\_\_%
- e. Private Insurance \_\_\_\_\_%
- f. Sliding Fee Scale Patients \_\_\_\_\_%
- g. Self-Pay / No Insurance \_\_\_\_\_%



**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION  
SECTION D – Applying Physician Information Sheet**

Department of State Number \_\_\_\_\_ National Provider Identifier \_\_\_\_\_

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ M.I. \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Office # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email \_\_\_\_\_

Street Address \_\_\_\_\_

P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Medical Discipline \_\_\_\_\_ Subspecialty \_\_\_\_\_

Home Country \_\_\_\_\_ Date of Birth \_\_\_\_\_

**EDUCATIONAL INFORMATION**

**Residency Program:**

Training Discipline \_\_\_\_\_

Name of Institution \_\_\_\_\_

Location of Institution \_\_\_\_\_

Graduation Date \_\_\_\_\_ If not complete, expected completion date: \_\_\_\_\_

Certifications Held \_\_\_\_\_

**Medical School Education:**

Name of Institution \_\_\_\_\_

Location \_\_\_\_\_

Graduation Date \_\_\_\_\_

**Fellowship Training (if applicable):**

Training Discipline \_\_\_\_\_

Name of Institution \_\_\_\_\_

Location \_\_\_\_\_

Graduation Date \_\_\_\_\_ If not complete, expected completion date: \_\_\_\_\_

Certifications Held \_\_\_\_\_

**MISSISSIPPI MEDICAL LICENSURE INFORMATION**

Has the physician received a Mississippi Medical License?  Yes  No

If not, has the physician applied for a Mississippi Medical License?  Yes  No





**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION  
SECTION E – Proof of Health Professional Shortage Designation**

**Please label this section E and submit the following information in the order listed.**

1. Proof of Health Professional Shortage Area (HPSA) designation. The practice site must be physically located in a currently designated federal HPSA or serve patients from a currently designated federal HPSA.

Obtain proof of HPSA designation from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) website at: [Find Shortage Areas by Address \(hrsa.gov\)](https://www.hrsa.gov/shortage)

Please be advised that HPSA designations must be current on the date the U.S. Department of State reviews the application and on the date the INS approves the J-1 visa waiver. Therefore, any application submitted to the Mississippi State Department of Health at the end of the three-year HPSA designation cycle may be summarily denied if the renewal of the HPSA designation is not obtained.

2. Evidence to verify that other avenues, regionally and nationally, to secure a physician not bound by the 2-year home residence requirement have been undertaken.

The recruitment information must state the specific position listed in this application and the practice site location. Ads must contain date information that can be used to verify at least three (3) months of recruitment effort that had regional and national reach.

3. Current state or federal prevailing wage information for same type position and geographic area.



**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION  
SECTION F – Documentation for Placement of Non-HPSAs**

**If this application is for a placement in a Non-HPSA, label this section F and submit the following information in the order listed.**

Patient origin data (by county) for previous calendar year.



**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION  
SECTION G – Addendum for Specialist Applicants**

**If this application is for placement of a specialist, label this section G and provide the following information in the order listed.**

1. A brief description (not to exceed one paragraph) of some of the types of illnesses, diseases, or health conditions treated by the specialty discipline.
2. Proof that the practice site is located in a Physician Scarcity Area (PSA) for specialists. If the practice site is not located in a PSA for specialist, provide the information requested in #3 below.
3. A brief description (not to exceed one paragraph) of the need related to this specialty discipline in the HPSA to be served. The information may include prevalence or incidence data, expected increases in diseases, illnesses and health conditions related to the specialty discipline, expected increases in patient volume, wait times for appointments, etc.



**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION  
SECTION H – Legal Notice Publication Requirement**

**Please label this section H and submit the following information in the order listed.**

The sponsoring health care facility is required to publish a legal notice in a newspaper of general circulation announcing intent to request support for a J-1 Visa Waiver. The notice must contain the language below. Proof of Publication and a copy of the notice must be submitted with the application.

**Format for Legal Notice Publication**

[Name of sponsoring facility and complete mailing address] is requesting that the Mississippi State Department of Health support a J-1 Visa waiver of the two-year foreign residency requirement of a (physician discipline type) in exchange for the provider providing healthcare services to [name of underserved area], an underserved area of the state, if approved by the U.S. Department of State.

Letters of support or opposition may be sent to the Director, Office of Rural Health and Primary Care, Mississippi State Department of Health, P.O. Box 1700, Jackson, MS 39215-1700. Any interested party has 21 calendar days from the date of this publication to submit letters.

Copies of letters may be obtained from the Office of Rural Health and Primary Care at the Mississippi State Department of Health.



**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION  
SECTION I – Physician Assurances**

**Please label this section I. By initialing, I am certifying that the information submitted in this application is correct and true to the best of my knowledge.**

Initial I, \_\_\_\_\_ Printed Name

hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1101, that I do not now have pending nor am I submitting during the pendency of this request, another request to any United States Government department of agency or any state department of public health, or equivalent, other than the Mississippi State Department of Health, to act on my behalf in any matter relating to a waiver of my two-year home country physical presence requirement.

Initial I do hereby declare and certify that the Sponsoring Medical Facility, will submit the MSDH J-1 Visa Waiver Physician Employment Verification Form for the initial 30 days after my employment begins and annual thereafter, until my three-year commitment is completed. I understand that failure to submit this report accurately and completely will result in a report of non-compliance to the U.S. Immigration and Naturalization Service.

Initial I hereby declare and certify under penalty of the provisions of 18 U.S.C. 1001, that the practice site(s) listed in this application, is in a primary medical care or mental Health Professional Shortage Area and/or provides medical care to citizens of a primary medical care or mental Health Professional Shortage Area. I also hereby declare and certify, that the sponsoring facility provides medical care services to Medicare and Medicaid-eligible patients, indigent patients, and uninsured patients.

Initial I further declare and certify that I have no contractual obligation to return to my home country. (If such a contractual obligation exists, the J-1 Physician must obtain a letter of “no objection” from the home country or the embassy in Washington D.C.).

Initial I agree to accept assignment under Section 1842 (b)(3)(ii) of the Social Security Act as full payment for all services for which payment may be made under Part B of Title XVII of such Act (Medicare).

Initial I hereby do certify the following: that the Sponsoring Medical Facility has read and intends to comply with the Mississippi Conrad State 30 J-1 Visa Waiver Program Guidelines. That the Applying Physician is not a relative or acquaintance of the employer. That the Sponsoring Medical Facility has funds currently available to support the requested position, including support personnel. That the Sponsoring Medical Facility is providing a salary for the applying physician that is comparable to U.S. physicians in the geographic area. That the Sponsoring Medical Facility was not successful with attempts to recruit a U.S. physician for this position. That the Sponsoring Medical Facility will notify the MSDH if the Applying Physician ceases to work full time, ends employment, or plans to petition the United States Citizen and Immigration Services for early termination of the three-year employment obligation period because the facility closes or due to extenuating circumstances. That the Sponsoring Medical Facility agrees to site visits by the MSDH.

\_\_\_\_\_  
**Original Signature**

\_\_\_\_\_  
**Date**



**MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM APPLICATION  
SECTION J – Employer Assurances**

**Please label this section J. By initialing, I am certifying that the information submitted in this application is correct and true to the best of my knowledge.**

Initial I, (please print) \_\_\_\_\_, hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1001, that the practice site(s) listed in this application, is located in a primary medicalcare or mental Health Professional Shortage Area and/or provides medical care to citizens of a primary medical care or mental Health Professional Shortage Area. I also hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1001, that the facility listed above provides medical care services to Medicare and Medicaid-eligible patients, indigent patients, and uninsured patients.

Initial I hereby certify that the Sponsoring Medical Facility, \_\_\_\_\_, has made a contractual offer for three (3) years of full-time (40 hours per week) employment to the Applying Physician, \_\_\_\_\_, to practice medicine at a practice site that is either in a geographic area designated by the Secretary of the Department of Health and Human Services as having a shortage of health care professionals or serves residents of such a designated shortage area. The Sponsoring Medical Facility understands that if the waiver is approved, the Applying Physician must begin employment at this practice site within 90 days of receiving the waiver.

Initial I do hereby declare and certify, that the Sponsoring Medical Facility will submit the MSDH Annual J-1 Visa Waiver Physician Employment Verification Form.

Initial I hereby do certify the following: that the Sponsoring Medical Facility has read and intends to comply with the Mississippi Conrad State 30 J-1 Visa Waiver Program Guidelines; that the Applying Physician is not a relative or acquaintance of the employer; that the Sponsoring Medical Facility has funds currently available to support the requested position, including support personnel; that the Sponsoring Medical Facility is providing a salary for the applying physician that is comparable to U.S. physicians in the geographic area; that the Sponsoring Medical Facility was not successful with attempts to recruit a U.S. physician for this position; that should the waiver be approved, the Sponsoring Medical Facility will notify the Mississippi State Department of Health (MSDH) within 30 days of the physician’s start date, and will thereafter complete and submit the Annual J-1 Visa Waiver Physician Employment Verification Form; that the Sponsoring Medical Facility will notify MSDH if the Applying Physician ceases to work full time, ends employment, or plans to petition the United States Citizen and Immigration Services for early termination of the three-year employment obligation period because the facility closes or due to extenuating circumstances; that the Sponsoring Medical Facility agrees to site visits by the MSDH; that the Sponsoring Medical Facility understands that submission of this application to MSDH does not guarantee that MSDH will recommend approval of the application to the federal level; and furthermore that, an approval recommendation by MSDH to the federal level does not guarantee that the application for the J-1 Visa Waiver will be approved by the United States Citizen and Immigration Services.

\_\_\_\_\_  
**Original Signature**

\_\_\_\_\_  
**Date**