PHYSICIAN RECRUITMENT 101

Designed specifically for those new to the field, or those desiring a refresher course in physician recruitment techniques and approaches.
Welcome to Physician Recruitment 101

Every year at our annual education forum, we receive overwhelming feedback from enthusiastic participants of "Physician Recruitment 101."

The 101 program is for those who are new to the field of in-house physician recruitment. It is also perfect for you if you want a refresher course in physician recruitment techniques and approaches. As you add new blocks to your recruitment foundation, you'll appreciate the insights you will discover in 101.

By using this guide, you can get a jump-start on physician recruitment and the 101 course. In it, you'll find valuable information and resources that you will use in your professional life for years to come. You'll learn from the best and brightest our industry has to offer.

We've developed this study guide with generous assistance from VISTA Staffing Solutions, an ASPR corporate contributor. We appreciate VISTA's efforts on our behalf, as well as all of our corporate contributors. We greatly appreciate their support.

Utilize this study guide, take full advantage of what the 101 course has to offer, and take that first step to do everything in your power to improve yourself and the recruiting process.

Dana Butterfield
ASPR, Executive Director

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800.366.1884  www.vistastaff.com
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Introduction:

Getting organized for recruitment is important because it is a reflection on you and your organization. Recruitment is an important service that you provide for your organization and recruitment is essential to your organizations ability to provide excellent patient care. Your organizations budget is dependent upon timely, successful recruitment and consistent revenue generation. By developing a well-organized cost effective recruitment program your future as a recruiter and your organizations future will be successful.

A) When preparing for recruiting you should develop and organize your tools including:
   - Establish processes,
   - Creating flow charts & forms
   - Reviewing employment information
   - Establishing a candidate tracking system
   - Creating relationships with vendors and obtaining recruitment resources

B) Your Processes can be sorted into pre hire and post hire activities.
   Pre hire processes include:
   - Request for Position/Justification
   - Approval to Recruit for New Position
   - Sourcing Candidates
   - Screening CV’s
   - Interviewing Candidates
   - Reference Checking
   - Offer Position

   Post hire processes include:
   - Relocation
   - Orientation
   - New Provider Promotion
   - Practice Startup and Development
   - Retention
   - Performance Evaluations

C) The following are the important forms to create that you will use on a regular basis with your recruiting process:
   - Initial Contact Questionnaire
   - Employment Application
   - Position Justification
   - Interview Critique of Candidate
   - Interview Questions
   - Reference Check
   - Credentialing Checklist
   - Post Interview Survey
   - New Hire Checklist
   - Orientation Checklist
D) The next step after defining your process and creating your forms is to educate yourself with the key information related to employing your new physician including:

**Benefits:** Create a summary sheet with all benefits and obtain a summary plan description to ensure you will know the details of the benefit plans offered to the physician.

**Employment Agreement:** Obtain the contracts and review with your attorney or administrator to ensure you know what it says in lay terms and what sections may be amended or negotiated for new physicians joining your practice.

**Marketing:** Review the plan to promote your new physician with your marketing department to ensure you are familiar with the plan and can communicate it effectively with the new physician.

**Credentialing:** Meet with your Medical Staff office at the hospital or clinic to ensure you are aware of educational and training requirements, and the criteria for obtaining privileges.

**Practice Descriptions:** These will be helpful with marketing your position. The profile will give the basics on the position, hospital and community. These can also be used for web site posting or direct mail.

**Evaluation System:** Obtain the information on how your new physician will be evaluated, how often they will be evaluated and by whom.

**Know your Staff - Hospital & Community:** By having a thorough understanding you will know what kind of physician is going to be the right for your organization.

E) It is important to establish committees or work groups to assist with recruitment planning and interviewing candidates.

- The Growth Committee role is to create and implement the Strategic Growth Plan of the System by identifying the current and future market share opportunities to meet the revenue expectations of the System.

- The Recruitment Committee’s role is to review requests for new positions, pre-screen interested candidates, and interview candidates on site, review candidates for hire, serve as a liaison to departments.

F) The Medical Staff Plan Analysis will allow you to identify current market share and future growth potential in your service area by reviewing the following data:

- Projected Growth of Service Area
- Demographics of Service Area
- Patient Billing Data by Physician
- Patient Visit Data by Physician
- Competitors Physician/Provider Information
- Discharge Data for Service Area Hospitals
- Discharge Data for Service Area Surgery Centers
# LAWFUL AND UNLAWFUL INTERVIEW INQUIRIES

Questions You Can and Cannot Ask During an Interview

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<thead>
<tr>
<th>SUBJECT</th>
<th>LAWFUL INQUIRIES</th>
<th>UNLAWFUL INQUIRIES</th>
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</table>
| Name    | Re: Work reference and educational checks such as:  
1. Name Change  
2. Assumed Name  
3. Nicknames  
4. Different Names | Any inquiry about the name that would indicate:  
1. Lineage, Ancestry, National Origin or Descent  
2. Name change by court order, marriage, etc. |
| Marital & Family Status | 1. Can the applicant meet the work schedules  
2. Activities that may hinder the meeting of attendance requirements | Any inquiry regarding:  
1. Marital status  
2. Single or engaged status  
3. # & age of children  
4. Pregnancy  
5. Which limits job opportunity  
6. Where spouse works |
| Age     | 1. If minor (under age 18) requires proof of age, in form of a work permit.  
2. Require proof of age after hire by birth certificate  
3. Are you 18 years of age or older? | 1. Require to produce proof of age before hire in the form of a birth certificate or baptismal record  
2. What is applicant’s age?  
(NOTE: Age 40 or older is the protected age group) |
| Disability | 1. Ask applicants if they can perform specific duties of the job  
2. Require the applicant to demonstrate or describe the job function  
3. Ask if the applicant can meet the attendance requirements of the position  
4. Request the applicant to make known any reasonable accommodation needed in a reasonable amount of time prior to testing | 1. Ask the applicant how they became disabled  
2. Ask about prognosis  
3. Inquire about worker’s compensation history  
4. Ask about the amount of leave time required  
5. Require medical exam prior to making the job offer |
| Sex     | The burden of proof tests with the employer to prove that a Bona Fide Occupational Qualification (BFOQ) does exist and that all members of the affected class are incapable of performing the job. | 1. Any inquiry which would restrict anyone on the basis of their sex unless bona fide  
2. Sex is not a BFOQ because job is physically the capacity of some women |
G) Once you have identified a search to conduct based on a Medical Staff plan it is important to further verify the position by completing a justification for final approval of the position by the department or Board of Directors. This will also serve as an excellent information source and referral for you to recruit the new physician.
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<tr>
<th>SUBJECT</th>
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<th>UNLAWFUL INQUIRIES</th>
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</thead>
<tbody>
<tr>
<td>Ancestry or National Origin</td>
<td>Languages applicant reads, speaks or writes fluently</td>
<td>1. Inquiries into applicant’s lineage, ancestry, national origin, descent, birthplace or mother tongue 2. National origin or parents or spouse, etc.</td>
</tr>
<tr>
<td>Education</td>
<td>1. Applicant’s academic, vocational or professional education 2. Schools attended 3. Inquiry into language skills (specific)</td>
<td>1. Affiliation of school (religious, racial or nationality) 2. What is the mother tongue of the school 3. How was foreign language ability acquired</td>
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<td>Experience</td>
<td>1. Work experience 2. Other countries visited</td>
<td></td>
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<tr>
<td>Conviction, Arrest and Court Records</td>
<td>Inquiry into actual convictions which relates reasonably to fitness to perform a particular job</td>
<td>1. Relating to arrests 2. To ask and/or check into arrest, court conviction records; if not substantially related to the responsibilities of the job</td>
</tr>
<tr>
<td>Relatives</td>
<td>1. Names of relatives already employed by this organization 2. Names and address of parent or guardian of minor applicant</td>
<td>Names and addresses of relatives on adult application</td>
</tr>
<tr>
<td>*Notify in Case of Emergency</td>
<td>*Names of persons to be notified</td>
<td>Names and addresses of relatives to be notified</td>
</tr>
<tr>
<td>Organizations</td>
<td>Inquiry into applicant’s membership in organizations which applicant considers relevant to the job</td>
<td>1. List all organizations, clubs, societies and lodges to which you belong 2. Specifically ask – if reveals race, color, religion, etc.</td>
</tr>
<tr>
<td>Credit Rating</td>
<td>None</td>
<td>Any questions concerning credit rating, religion, etc.</td>
</tr>
<tr>
<td>Race, Color and/or Physical Characteristic</td>
<td>Any inquiry that is general in nature regarding physical characteristics such as scars, etc.</td>
<td>1. All questions regarding race, color of skin, eyes, hair, etc. 2. Height and weight, unless a BFOQ</td>
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<tr>
<td>Address and Duration of Residence</td>
<td>1. Applicant’s address 2. Place and length of current and previous addresses 3. How long a resident of this city or state</td>
<td>1. Specific inquiry into foreign address which would indicate national origin 2. Names or relationship of persons with whom applicant resides 3. Whether applicant rents or owns home</td>
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<tr>
<td>SUBJECT</td>
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<td>UNLAWFUL INQUIRIES</td>
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</table>
| Birthplace           | After employment, can applicant submit a birth certificate or proof of U.S. citizenship? | 1. Birthplace of applicant, parents, spouse, etc.  
2. Requirements of proof before hire  
3. Any other inquiry that might identify religious denomination or Customs. |
| Military Record      | 1. Type of education as related to a particular job  
2. Type of training as related to a particular job  
3. Produce DD214 (military record). | 1. Type of discharge |
| Photograph           | Only after hire, for identification | 1. Request photo before employment  
2. Request photo affixed to application  
3. Make photo submission optional  
4. Require photo after interview and before hire |
| Citizenship          | Does applicant have a legal right to work in the U.S.? | 1. What is applicant’s citizenship?  
2. Are applicant, parents, spouse, etc. naturalized or native-born citizens?  
3. Dates of acquiring US citizenship  
4. Applicant required to produce naturalization or 1st papers |
| Religion or Creed    | Absolutely no lawful inquiry | 1. Inquiry into applicant’s religious denomination, religious affiliations, church, parish, pastor, priest, rabbi, or religious holidays observed  
2. Applicant may not be told, “This is a (Protestant, Catholic or Jewish) organization.” |
| Birth Control        | Absolutely no lawful inquiry | Inquiry into applicant’s capacity to reproduce or with regard to family planning |
| Miscellaneous        | Notice to applicant that any misstatement or omission of material facts in the application may be cause for dismissal | |

**NOTE:** Inquiries which would otherwise be deemed lawful, may, in certain circumstances, be deemed as evidence of unlawful discrimination when the inquiry seeks to elicit information about a selection criteria which is not job related and has a disproportionate burdensome effect upon a minority group and cannot be justified by business necessity.
Introduction:
After you have given some thought to exactly what type of skills and qualifications and candidate will need to be successful in your position, it’s important to consider some relevant Employment Law. It’s absolutely important to review the following list BEFORE meeting or speaking with a candidate. Unlawful commentary, conversation or inquiry could lead to a damaging lawsuit.

Americans with Disabilities Act: Signed into law on July 26, 1990. The employment provisions of the ADA prohibit employers from discriminating against qualified individuals with disabilities in employment practices including: application procedures, hiring compensation, training, advancement and discharge.

Core Requirements of the ADA are:
- To prohibit disqualification of disabled applicants or employees because of their inability to perform marginal or non-essential job functions.
- To require employers to demonstrate the job-relatedness and business necessity of requirements of selection criteria that tend to screen out disabled applicants.
- To require employers to make reasonable accommodation to help disabled applicants or employees meet legitimate criteria.

Equal Employment Opportunity and Affirmative Action Policy
Companies may have a policy that outlines it’s practice to recruit, hire, train and promote qualified persons without discrimination against any employee or applicant because of race, religion, color, sex, physical or mental disability, national origin, marital status, sexual orientation, age, or status as a special disabled veteran or veteran of the Vietnam era, except where a bona fide occupational qualification exists under applicable regulation.
CANDIDATE SOURCING, PART I
Prepared by: Carol Sullivan

Introduction:
Sourcing the solution to your physician recruitment challenges requires background knowledge and an understanding of effective recruitment sourcing techniques and advertising communications. Critical to the success of your sourcing and recruitment program are: a thorough understanding of your organization’s physician staffing needs, knowing what your organization can offer, identification and establishment of an effective employer brand, and a well-planned and timed sourcing and recruiting/advertising plan. Sourcing Solutions in Physician Recruitment will introduce the major elements comprised in a comprehensive, multi-faceted, outreach initiative to source physicians today.

A) Understand the physician candidate market and segments of this workforce you need to attract and retain such as:
   - Analyzing what your organization needs
   - The changing healthcare delivery landscape
   - Market research – candidate demographics and job-selection criteria
   - Comprehensive marketing

B) Develop a compelling employment message
   - The organization’s compensation attributes
   - Your organization’s competitive advantage

C) Identify and build your employer brand by:
   - Differentiating your organization from the competition (Employer of choice attributes)
   - What is an employer brand?
   - Branding an organization to aid recruitment.
   - Building the employer brand through effective marketing, brand management and recruitment advertising efforts.
   - Incorporating the employer brand into sourcing strategies and advertising objectives.

D) Sourcing and Recruitment Objectives
   - Creating awareness
   - Positioning your organization in the market.
   - Generating physician candidate leads and responses.
   - Short-term tactical methods
   - Multiple communications/media channels
   - Traditional and non-traditional methods

References:
2. www.nasrecruitment.com
CANDIDATE SOURCING, PART II
Prepared by: Donna Loy

Introduction:
There are 3 major functions in recruiting physicians, sourcing, interviewing, and closing. Listed below is information to aid you in sourcing physician candidates to match your need. A basic knowledge of where physicians come from and what is required by that specialty to become “Board Certified” helps to focus your sourcing efforts. It helps to understand where physicians want to practice. If the averages tell you that there are only 5 physicians are going to be attracted to your particular area of the country and your need is to hire 10, the job is going to be very difficult. Understanding what attracts physicians to practices allows you to narrow your search to physicians who will be open to the opportunity you have available.

To be able make your opportunity attractive to physicians you would like to recruit, you must understand the issues that priorities to them. Newly graduated physicians are facing a heavy debt load and often need the stability of guaranteed income or are in an employed status. Who is most likely to be interested in your opportunity and how do you find them?

A) Sourcing methods:
- Print Advertising – journal and newspaper
- Internet Advertising – Job-hunting sites and specialty sites
- Direct mail
- Word of Mouth
- Residency
- National and Regional Meetings
- Search Firms

B) What are the needs of the physicians you are recruiting?
- Geographic location
- Colleague
- Compensation
- Lifestyle
- Family Considerations

C) Internet Advantages:
- Specialty Sites
- Speed – job posting available within hours
- Combination advertising – Internet and journal or print
- Job posting can be viewed at any time of the day or night

D) Mailing lists:
- Information provided by the AMA and AOA
- Purchase multiple uses of list
- Ability to target search on physicians likely to be interested in your opportunity

E) Data Base services:
- Physicians prescreened as to what opportunity would interest them
- Physician profile available
- Eliminates cold calling
F) Academic placement services:
   - Captive Audience
   - Reasonable Cost
   - Web advertising and hard copy
   - Respected Source

G) Residency Programs:
   - Captive Audience
   - Able to present your opportunities to Residents directly
   - Post positions in hard copy also

H) National and Regional Meetings:
   - Good public relations
   - Face-to-Face contact
   - Make connection with future applicants

I) Search Firms:
   - Retained
   - Contingency

J) Make sure the candidates can find you

References:

AM News, Medical School Enrollment
AM News, Medical School Debt
AM News, Medical School Graduates
AMA
Introduction:
Recruiting, selecting and screening candidates, requires knowledge in the areas of recruitment, employment law, human resource planning, state and federal contract law, credentialing and privileging. As with other phases of the overall recruitment process background knowledge, preparation and timing are key dimensions to any successful implementation of recruitment strategies.

There is also an art and a science to the interview, selection, screening and evaluation process when it comes to recruiting and retaining the best candidates for your organization. We will introduce you to the major areas of competency we think make a difference in making your recruitment process more targeted and successful.

A) Laws to know:
• EEOC Civil Rights Act
• Age Discrimination in Employment Act
• Americans with Disabilities Act
• The Equal Pay Act
• State laws and contracts

B) Selection and screening:
• Keys to reviewing CVs
• Behavioral interviewing
• The Interview process environment and team
• Reference checking-Authorization and release and disclosure forms
• Negligent Hiring and Employer due diligence in background checking
• Criminal Background Checks
• Evaluation techniques and process

C) Credentialing and Privileging:
• Definition of credentialing and purpose
• NCQA and JCAHO standards
• Definition of privileging and purpose
• State licensure
• Timelines

References:
5. www.EEOC.gov. 2006
9. www.ncqa.org
10. www.jcaho.org
11. www.fsmb.org
Introduction:

At times the thought of planning a site visit can be daunting. That feeling can be escalated if you are given a short time table to make that happen. There are so many details to consider and numerous individuals that need to be contacted in order to pull together a well-planned itinerary. We would like to make some suggestions of items you should keep in mind when planning an itinerary or site visit for a physician candidate. A basic concept would be the more planning and attention to details, theoretically the more smoothly the day should flow.

There are always unexpected things that will occur. Having a recruitment team that is flexible and able to think quickly when you have an unexpected opening on your schedule will be important. A physician may be called to attend to a medical emergency, which leaves you with an open hour on your agenda for your candidate. If reasonable consider a short community tour, even if you have already scheduled a real estate visit for your candidate. Both tours will be sharing some of the same information, but that will make it easier for the physician to remember his/her visit and to possibly ask additional questions.

An important thing to remember is that pre-planning and asking questions before the candidate arrives will help you customize the visit with the items that are most important to that physician. Each visit/itinerary will present a different set of challenges, but they will have been worth it when the physician signs with your group or hospital. Your candidate will appreciate and remember your attention to detail and likely thank you for doing so.

When preparing an itinerary or site visit please keep the following items in mind:

A) Significant Other/Spouse Preliminary Interview Survey
   • Do you require assistance in your personal job search?
   • Would you like information on area school systems?
   • Is children’s day care of interest to you?
   • Would you like to arrange a real estate tour?
   • Please tell us about other areas of interest or concerns that you may have.

B) First Impressions Are Lasting
   • Make travel arrangements two weeks in advance if possible
   • Make hotel arrangements and set up direct bill to include incidental expenses
   • Gift basket in room (include disposable camera and inexpensive toys if children are visiting).
   • Reimburse for reasonable travel expenses (meals on the road, tolls, taxis and mileage)
   • Involve people from your community, hospital administration, and medical staff in the visit.

C) Screening:
   • Interviewers should ask pertinent questions relating to how this physician will fit into the medical staff and community.
   • Make sure all interviewers provide you with feedback via the “Confidential Interview Evaluation Sheet” in a timely manner (within five days)

D) Professional Aspects of the Opportunity
   • Introduce physicians to the operations managers of the departments he/she be using and ask them to provide the physician with information with regards to their units and how they operate.
• Make sure the physicians who are interviewing the candidate show him/her around the office and where the new physician’s office space would be. Get the entire staff involved (medical assistants, receptionist, office manager, etc.)

E) Children’s Needs:
• Be aware of local activities available to children of various ages in your community or surrounding area.
• Will a certified babysitter service be needed?

F) Recruiting the Spouse/Significant Other:
• Does the spouse want to accompany the physician candidate on the interview? Find out how your administration feels about this.

G) Single Physicians and Physicians Without Children:
• Housing needs may be different so find out that ahead of time.
• Ask questions before the day of the interview so that you are prepared.

H) Personalizing the Visit
• Be prepared for the unexpected.

I) Follow Up
• Collect and review evaluation sheets.
• Call candidate to follow up on any outstanding questions/concerns. Find out if candidate is interested in your opportunity.
<table>
<thead>
<tr>
<th>Candidate’s Name:</th>
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<tr>
<td>Specialty/Position:</td>
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<td>Date of Interview:</td>
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<td>Interviewer:</td>
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Please evaluate this candidate on the areas indicated below by placing a check in the appropriate box, along with any comments in the sections provided.

1. **First Impression**
   - Outstanding 
   - Avg 
   - Average 
   - Avg
   - Unacceptable
   - Comments: 

2. **Professional Appearance**
   - Outstanding 
   - Avg 
   - Average 
   - Avg
   - Unacceptable
   - Comments: 

3. **Practice Style/Philosophy**
   - Outstanding 
   - Avg 
   - Average 
   - Avg
   - Unacceptable
   - Comments: 

4. **Knowledge Base for Position**
   - Outstanding 
   - Avg 
   - Average 
   - Avg
   - Unacceptable
   - Comments: 

5. **Level of Practical Experience**
   - Outstanding 
   - Avg 
   - Average 
   - Avg
   - Unacceptable
   - Comments: 

6. **Interpersonal Skills**
   - Outstanding 
   - Avg 
   - Average 
   - Avg
   - Unacceptable
   - Comments: 

7. **Ability to Communicate**
   - Outstanding 
   - Avg 
   - Average 
   - Avg
   - Unacceptable
   - Comments: 

8. **Attitude and Enthusiasm**
   - Outstanding 
   - Avg 
   - Average 
   - Avg
   - Unacceptable
   - Comments: 


9. **Goals and Ambition**

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<tr>
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<th>Outstanding</th>
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<th>Average</th>
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<tr>
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10. **Capability**

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11. **Ability to be a Team Player**

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<th>Avg Unacceptable</th>
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12. **Leadership Skills**

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<td>Comments</td>
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13. **Attitude re: Pt/Cust Satisfaction**

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<th>Avg Unacceptable</th>
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14. **Overall Appraisal**

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<th>Avg Unacceptable</th>
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Additional Comments:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**RECOMMENDATIONS:**

- [ ] Recommend an offer be made
- [ ] Second interview suggested
- [ ] Continue looking

**INTERVIEWER’S SIGNATURE:** ___________________________ **Date:** ______________

**PLEASE RETURN TO:** Christine Bourbeau  
Physician Services Liaison  
Bristol Hospital, Incorporated  
Post Office Box 977  
Bristol, CT 06011-0977  
Phone: 860.585.3300  
Fax: 860.585.3036
PHYSICIAN SITE VISIT POLICY
Bristol Hospital, Incorporated

Our goal is to make your visit as informative and comfortable as possible. By the time a site visit is being planned, we are very interested in you joining our hospital family. The site visit gives both parties the opportunity to learn more about each other, see and experience the community, and confirm what has been discussed in previous conversations.

1. Bristol Hospital will arrange and pay for round trip airfare for you and your significant other. A minimum notice of two weeks is required so all arrangements can be made in advance to ensure a complete and thorough visit. There are occasions when you may be asked to stay over on Saturday night in order for us to take advantage of the discounted rate, which at times is substantially lower. We hope that this will not be an inconvenience for you. Many of the physicians who visit like to spend the extra day or two touring the community.

2. Upon prior approval, Bristol Hospital will arrange and pay for your children as well. While your children are welcome, we have found that leaving the children with someone at home will allow you to more fully concentrate on all aspects of the opportunity and community.

3. Should canceling or rescheduling your site visit be necessary, please contact the Physician Recruitment Department at your very earliest convenience in order for us to notify all those involved in your site visit.

4. If airline tickets were purchased for your site visit, and you are canceling your visit, you will be asked to return the tickets to the Physician Recruitment Department within three business days. If you would like to purchase the tickets for future use, please notify the Recruitment Department and we will make arrangements for you to mail a check payable to “Bristol Hospital” in the amount listed on the ticket(s).

5. Bristol Hospital will arrange and directly pay for hotel accommodations. Reimbursement will be made to you for the use of a rental car and incidental expenses. Original receipts should be mailed to the Physician Recruitment Department within one week after your site visit. A check will be mailed to you within two weeks of us receiving your receipts. If you drive your own car, you will be reimbursed 44.5 cents per mile upon us receiving written records of your total mileage.

6. The Physician Recruitment Department will provide a detailed itinerary to you in advance.

If you have any questions regarding your site visit, please contact Christine Bourbeau in the Physician Recruitment Department at 800.892.3846.
Email address: cbourbeau@brishosp.chime.org
ITINERARY

1) Donald Mender, MD
   Orthopedic Surgeon Candidate
   Bristol Orthopedics, LLC

Wednesday, April 24, 2006

4:19 p.m.  Arrival at Bradley International Airport, US Air Flight #999
           Hertz Car Rental Confirmation #456789
           Farmington Marriott Hotel Confirmation #12345
           **Hotel Phone number: 678.1000**
           Directions to hotel attached

Thursday, April 25, 2006

7:50 a.m.  Meet Christine Bourbeau, Physician Services Liaison,
           **Meeting Location:** Lobby of Farmington Marriott Hotel

8:30 a.m.  Thomas D. Kennedy, III
           President, Bristol Hospital, Incorporated
           **Meeting Location:** Mr. Kennedy’s Administrative Office

9:30 a.m.  Tour of Hospital
           Teresa Kukolja
           Vice President, Patient Care Services

10:30 a.m. Lawrence Levine, MD
            Director, Emergency Department
            **Meeting Location:** Dr. Levine’s Office

11:30 a.m. Meeting with Radiologists
           John Walker, MD, Dennis Ferguson, MD, Stewart Bober, MD, Folco Scappaticci,
           & Carlos Badiola
           **Meeting Location:** 987 Farmington Avenue, Bristol Hospital

12:30 p.m. Luncheon Meeting
           Anthony Parisi, MD, Chairman, Department of Orthopaedics
           Michael LeGeyt, MD, Staff Orthopedic Surgeon
           Daniel Scoppetta, MD, Chief of Staff & General Surgeon
           **Meeting Location:** Bristol Hospital Board Room

2:00 p.m.  Ann Altafer, Director, Preoperative Services
           Debbie Rutledge-Holt, Operations Manager, Operating Room
           **Meeting Location:** Operating Room
3:00 p.m.  Community Tour
Christine Bourbeau, Physician Services Liaison
James Krawiecki, Realtor, ReMax First Choice Realty

5:00 p.m.  Return to Farmington Marriott

7:00 p.m.  Dinner at Apricot’s Restaurant - Farmington
Dr. Tony & Debbie Parisi; Drs. Michael & Christine LeGeyt
(Tony & Debbie Parisi will pick you up in the lobby at 6:45 p.m.)

Friday, April 26, 2006

8:30 a.m.  Meet Christine Bourbeau in lobby of hotel

9:00 a.m.  Breakfast Meeting with area Orthopedic Surgeons
Timothy McLaughlin, MD, Michael Cucka, MD,
Carl Bomar, MD, Scott Organ, MD

Meeting Location:  Level E Conference Room

10:30 a.m.  Visit Bristol Orthopedic, LLC Office Site
291 Queen Street, Bristol

12 Noon  Lunch
Tony Parisi, MD & Michael LeGeyt, MD

3:00 p.m.  Depart Bradley International Airport

5:15 p.m.  US Air Flight 123
 IMMIGRATION  
Prepared by: David Nyman

Introduction:  
One of the important areas that it is necessary to have a general understanding of to be successful in physician recruitment is immigration. As the number of international medical graduates that choose to practice in the United States continues to rise, this knowledge base is vital to make sure that the individuals are able to fulfill your needs. The attached articles provide a broad base of information on the different terms and concepts that you will encounter in your work and also what are some of the key rules and regulations that you should be cognizant of to be successful.

A) Areas that you should be knowledgeable about include:
   - J1 Visa
   - H1-b Visa
   - O-1 Visa
   - Permanent Resident
   - ECFMG
   - Home Residency Requirement
   - Interested Government Agency
   - Conrad State 30 program
   - Waivers

B) Concepts:
   - Applying for Visa
   - Who is a Qualified Candidate
   - Process for applying for Permanent Residency
   - Different types of Visa’s
VALUE IN SEARCH OF MEANING:
NATIONAL INTEREST WAIVER PRACTICE FOR PHYSICIANS

by Robert D. Aronson*

This article concerns the waiver of job offer/national interest waiver provisions pertaining to physicians working in designated medically underserved areas or within the Department of Veterans Affairs (VA). These provisions carve out certain special, profession-specific initiatives, mandating the Attorney General to approve national interest waivers for a select class of physicians who are willing to work in the profession for a stipulated period of five years (or, for grandfathered cases as described below, for three years) in designated medically underserved areas or VA facilities. As such, this class of physicians is exempted from the general national interest waiver standards as articulated in the Matter of New York Department of Transportation (NYSDOT). However, in its regulatory implementation of the statute, U.S. Citizenship and Immigration Services (hereinafter USCIS or Service) arguably has blunted the congressional intention of having these provisions serve as a proactive measure for facilitating the relocation of physicians to underserved practice sites.

By way of background, the national interest waiver classification was created in the Immigration and Nationality Act of 1990 (hereinafter, IMMIGACT90), although the concept of immigration serving the national interest certainly has its antecedents in previous legislative enactments. While there may have been little direct legislative history behind the national interest waiver provisions, the presumed underlying policy corresponds to the basic jurisprudential principle that the law is intended either to reward desirable behavior or to induce “socially beneficial cooperative behavior”—i.e., to get people to undertake socially desirable actions which they otherwise might not undertake. Therefore, while most employment-based cases for permanent residence rely upon a test of the U.S. labor market, the national interest waiver provisions recognize that an alien’s contributions to overall U.S. national interests can serve as an alternative basis for permanent residence.

In the initial period, physicians taking up employment positions in designated medically underserved areas were generally accorded favorable national interest waiver consideration. Specifically, the legacy U.S. Immigration and Naturalization Service (INS) Administrative Appeals Unit provided some guideline factors in the Mississippi Phosphate case, which identified seven factors that were to be favorably considered for national interest waiver purposes, including the improvement of health care.

In the ensuing period of time, many medical providers located in medically underserved communities utilized the national interest waiver provisions, which, incidentally, became a useful and powerful recruitment tool to get foreign physicians to practice in medically underserved practice locations. Legacy INS seemed to endorse the approvability of national interest waiver petitions by instructing that “the service centers should continue their past practice of favorably adjudicating most national interest wai-

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* Robert D. Aronson is a principal in the Minneapolis-based firm of Ingber & Aronson, P.A. He has held various leadership positions both within AILA and the medical communities on immigration issues pertaining to foreign physicians, and speaks and writes frequently on this area of the law. He holds his J.D. cum laude from the Indiana University School of Law and was a Fulbright Fellow at the Law Schools of Harvard University and Moscow State University. He is an Adjunct Professor at the University of St. Thomas, a former fellow of the Walter F. Mondale Leadership Institute, and currently serves as Vice Chair of the Hebrew Immigrant Aid Society (HIAS). He is also the liaison of the American Immigration Lawyers Association (AILA) on J-1 waiver matters with the Department of State. The author wishes to thank Salima Khakoo for her assistance with this article.

1 See INA §203(b)(2)(B)(ii).
5 Matter of [name not provided], EAC 92 091 50126 (AAU July 21, 1992).
ers for physicians who will be practicing in medically underserved areas of the United States.\textsuperscript{6}

However, this generally favorable disposition toward national interest waivers for physicians was altered dramatically with \textit{NYSDOT}, which ushered in a change from a fairly consistent pattern of approvals to a near blanket pattern of denials of physician cases. Yet, even in the post-\textit{NYSDOT} period, the underlying rationale for denying national interest waiver petitions for physicians remained somewhat uncertain. Some tribunals maintained that physicians working within designated medically underserved areas represented a local rather than national area of concern. Other cases relied upon a physician’s nonfulfillment of Prong 3 of \textit{NYSDOT}’s test, which requires a showing of the alien’s extraordinary abilities to counterbalance the law’s general preference for testing the U.S. labor market through the labor certification process.\textsuperscript{7} In any case, the prevailing sentiment of the Service was that “there is no indication in the legislative history, statute, regulations, or binding legal precedents that physicians as a group are exempted from the labor certification requirement.”\textsuperscript{8}

Yet, despite the removal of national interest waiver entitlement for physicians working in medically underserved areas, the U.S. health care system unquestionably exhibits certain highly distressing attributes of national importance, including:

- A grossly expensive national healthcare system that consumes over 14 percent of our nation’s GNP and which, unless checked, will carry major, negative implications to our nation’s fiscal integrity;\textsuperscript{9}
- A need to preserve the quality of physician services;
- A lack of adequate access to physician services, which has left many communities without acceptable physician coverage to address basic human needs. Specifically, roughly 37 million individuals in this country are without medical insurance and roughly 64 million people live in communities designated by the federal government as medically underserved, \textit{i.e.}, areas in which medical coverage falls short of minimally acceptable norms for adequate access to healthcare providers.\textsuperscript{10} Furthermore, this shortage pattern is disproportionately experienced by minorities and by many of the most vulnerable segments of our society, and is essentially an endemic situation affecting rural America;

- Growing evidence of a major national shortage in the number of practicing physicians working in both primary care and specialty medical disciplines that will have profound negative effects on the scope of and access to physician services, particularly given more intensive treatment needs by an aging population.\textsuperscript{11}

To this end, Congress has created a broad set of initiatives intended to facilitate the relocation and retention of physicians to designated medically underserved areas and facilities, including: the National Health Service Corporation, the Physicians Loan Repayment Plan, the Target Assistance Grant Program, the Community Rural Health Care Network, and the stepped up Medicare reimbursement schedules for designated rural and inner-city providers. The purpose of these measures is to enhance the relocation and retention of physicians working in designated medically underserved communities.

Although the legislative history is largely silent on this subject, the special national interest waiver provisions for physicians were presumably enacted to address the disequilibrium in the national healthcare system and to bring immigration law into alignment with other proactive measures intended to facilitate the relocation of physicians to medically underserved areas.

In distilled form, the statutory language contains the following provisions:

- A mandatory prescription requiring the Attorney General to approve an immigrant visa petition filed under the waiver of job offer/national interest waiver provisions to physicians working in


\textsuperscript{8} Matter of [name not provided], A75 385 444 (AAO Sept. 14, 1998).


designated medically underserved areas. Please note: whereas the general national interest waiver provisions provide the Attorney General with discretion to issue an approval, the physician-specific national interest waiver provisions create an obligatory mandate to grant approval.

- The affected class of beneficiaries include the following (to be read in the conjunctive):
  - any alien physician;
  - who agrees to work full time in a federally designated medically underserved area OR within a VA medical facility;
  - whose services had previously been found by a federal agency or a department of public health in any state to be in the public interest; and
  - who establishes the fulfillment of a stipulated period of employment service at the time permanent residence is to be granted through either the adjustment of status process or through consular processing.

- Both the immigrant visa petition and the adjustment application can be filed prior to the actual fulfillment of the required period of mandatory service, although permanent residence cannot actually be granted until the stipulated service requirement has been fulfilled;

- The required stipulated period of medical service generally is five years, although Congress specifically determined that a three-year period of service shall apply to "a physician for whom an application for a waiver was filed … prior to November 1, 1998";

- The period of employment for the mandatory service requirement shall be calculated in the aggregate and shall not include any period of employment in J-1 status, even if a J-1 physician was working in a designated medically underserved area and/or in a VA facility.12

Whereas the statutory provisions were signed into law on September 6, 1999, the regulations did not appear for roughly one year.13 As discussed below, it appears as though various regulatory provisions either directly contradict the statute or, at minimum, contradict the presumably expansive, proactive policy initiative inherent in the statute.

This article analyzes the current implementation of the waiver of job offer/national interest waiver provisions for physicians and, in particular, discusses the apparent disconnect between the statute and current implementation policy of USCIS. The primary sources of the law appear at INA §203(b)(2)(B)(ii) and 8 CFR §204.12 (petition process) and 8 CFR §245.18 (adjustment process). In addition, there is a certain complementary overlap between the national interest waiver provisions of the Act and the J-1 waiver provisions for physicians relocating to designated medically underserved areas.14

**Limitation to Primary Care Physicians**

The statute extends national interest waiver entitlement to “any alien physician” relocating for the required duration of practice to a designated medically underserved area. Yet, despite the clear statutory language which embraces any alien physician, the Service currently restricts national interest waiver entitlement solely to primary care physicians, i.e., front-line physician providers practicing in the areas of family medicine, general medicine, pediatrics, internal medicine, obstetric/gynecology, and psychiatry. The underlying rationale as provided by the Service is that the current system for making designations of medical underservice is based upon existing ratios between primary care providers and the general population, which, by implication would exclude medical specialists.15

There are two essential fallacies to the Service’s position. First, and perhaps most compelling, is the fact that the clear statutory language which embraces any alien physician, the Service currently restricts national interest waiver entitlement solely to primary care physicians, i.e., front-line physician providers practicing in the areas of family medicine, general medicine, pediatrics, internal medicine, obstetric/gynecology, and psychiatry. The underlying rationale as provided by the Service is that the current system for making designations of medical underservice is based upon existing ratios between primary care providers and the general population, which, by implication would exclude medical specialists.15

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12 Supra note 1.
14 See INA §214(l).
is essentially intended to provide a manageable, statistically based method of determining the adequacy of healthcare coverage. Therefore, within the Medicare program, a medical specialist working within a designated medically underserved area will qualify for Medicare incentive payment plans. In short, there is no requirement that the physician practice primary care medicine in order qualify for stepped-up Medicare reimbursement coverage; rather, the determinative factor is simply whether the medical specialist will be practicing medicine in a designated medically underserved area. Similarly, immigration benefits in medically underserved areas should not be limited to primary care physicians.

VA Situation

In addition to geographic areas and medical facilities designated as medically underserved, the waiver of job offer/national interest waiver provisions also extend to physicians working within medical facilities operated by the Department of Veterans Affairs. As is the case in medically underserved areas, the VA system has chronically suffered from an inability to recruit sufficient numbers of physicians owing to a variety of circumstances, including: perceived inferior working conditions, noncompetitive salary arrangements, the preponderance of a largely geriatric and socioeconomically depressed patient community, etc.

In contrast to the situation affecting physicians working in designated medically underserved areas, the VA system is not restricted solely to primary care medicine. As a result, VA facilities can avail themselves of the national interest waiver provisions not only in the recruitment of primary care physicians, but also for medical specialists.

Medically Underserved Designations

The federal government has two primary ways of designating physician shortage areas. The first is the Health Professional Shortage Area (HPSA) designation, which is applied to areas having a primary care physician-to-population ratio of 1:3500 or lower. In certain cases, the HPSA designation will be given if the primary care physician-to-population ratios are less than 1:3000. HPSA designations can be given to either an entire geopolitical unit (such as a county) or a sub-area (such as a census tract) or even to certain designated population groups or specific medical facilities.

The second federal designation is Medically Underserved Area/Medically Underserved Population (MUA/MUP). In many respects, the MUA/MUP schema represents a more exacting standard than the HPSA designation since it is not limited solely to physician-to-population ratios, but rather factors in a broader number of variables to determine the need for additional physicians in an area. The four variables used in a MUA/MUP designation are: (1) the ratio of primary care physicians to the area’s population; (2) the infant mortality rate; (3) the percentage of the population with income below the poverty level; and (4) the percentage of the population aged 65 or older. In general, though, the degree of medical underservice existing within MUA/MUP designated entities is considered less severe than is the case in HPSA-designated areas.

In order to qualify for national interest waiver entitlement, the physician needs to practice full time in a facility physically located in either a HPSA or an MUA/MUP. It is not sufficient simply to establish that the physician will treat patients drawn from designated medically underserved areas; rather, the determinative fact to establish is that the physician will be working in a full-time capacity in a facility physically located in a designated medically underserved area.

Conversely, there is no affirmative requirement for national interest waiver purposes to show that the physician actually treats indigent, minority, or “at-risk” patients. Rather, the law establishes a bright-line litmus test which simply presupposes that a physician physically practicing in a designated medically underserved area will indeed treat medically underserved segments of the community. While this presupposition is probably correct for physicians working within rural communities, it is probably not equally valid for physicians working within urban practice locations, given the close proximity of fully served neighborhoods (or census tracts) to areas designated as medically underserved.

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18 INA §203(b)(2)(B)(ii).
20 Public Health Service Act §330, 42 USC §254c.
21 8 CFR 204.12.
It also should be noted that in order to claim national interest waiver entitlement, an area needs to receive federal designation as medically underserved. Whereas many states have created their own systems for designating medically underserved communities or areas, such state-designated areas cannot serve as a basis for obtaining approval of a national interest waiver petition.

**Attestation Requirements**

The attestation requirement is perhaps the most chilling aspect of the national interest waiver provisions in physician practice. While the statute requires that “a Federal agency or a department of public health in any state needs to have previously determined that the alien physician’s work in such an area or at such facility was in the public interest,”\(^\text{22}\) the regulatory implementation of the statutory provisions creates a complicating, unnecessary, and self-defeating attestation requirement in three specific areas:

- A valid attestation from a federal agency needs to include a personal attestation statement on the physician’s practice capabilities,\(^\text{23}\) rather than simply an endorsement of the need for a physician working in the designated medically underserved area;
- An attestation issued by a state needs to be issued by the state’s centralized department of health,\(^\text{24}\) rather than from appropriate health departments at the county or local level; and
- An attestation needs to have been issued within six months prior to the filing of the national interest waiver petition,\(^\text{25}\) which essentially nullifies the ability to utilize J-1 waiver recommendations for national interest waiver purposes.

First, the regulations require that an attestation from a federal agency in support of a national interest waiver petition needs to endorse the physician’s practice capabilities,\(^\text{23}\) rather than simply an endorsement of the need for a physician working in the designated medically underserved area;

Second, although the statutory language specifically refers to a “department of public health in any State,” the regulations limit the public interest statement solely to the state department of public health. In so doing, the regulations disqualify local and county departments of health from issuing valid attestations and instead vest this authority solely upon the state’s centralized and often bureaucratic department of health. Aside from the inherent violation of the statutory injunction, this policy deprives a county or local agency, which presumably is well aware of local community needs, from undertaking a necessary and appropriate function in facilitating the relocation of physicians to a local community.

Third, the statute simply states that the attesting agency either at the federal or state level must have “previously determined that the alien physician’s work ... was in the public interest.”\(^\text{26}\) Regrettably, the implementing regulations require that, for national interest waiver purposes, the attestation statement must have been issued within the six-month period prior to the filing of the immigrant visa petition.\(^\text{27}\) Functionally, this is highly troubling in that it eliminates the ability of a J-1 waiver beneficiary to utilize the initial interested government agency waiver recommendation which has also been endorsed by the U.S. Department of State (DOS) and, ultimately, USCIS. In short, the merits of a physician’s relocation to a designated medically underserved area in many cases have already been exhaustively demonstrated as part of the J-1 waiver process. It would seem counterproductive to require the same physician to undergo yet another government

\(^{22}\) INA §204(b)(2)(B)(ii)(1)(bb).
\(^{23}\) 8 CFR 204.12 (c)(3)(i).
\(^{24}\) 8 CFR 204.12 (c)(3)(ii).
\(^{25}\) 8 CFR 204.12 (c)(3).
\(^{26}\) INA §204(b)(2)(B)(ii)(1)(bb).
\(^{27}\) Supra, note 25.
clearance process in order to gain approval for a situation which has previously been endorsed as being in the public interest.

**Section 212(e) Waiver Approval**

The Service’s regulations require that a J-1 physician provide evidence of a Service-issued waiver under the provisions of §212(e) of the Act in order to receive approval of a national interest waiver petition.\(^{28}\) In order to obtain permanent resident status through any available avenue (labor certification, national interest waiver, etc.), a current or previous J-1 physician needs to receive a §212(e) waiver\(^{29}\) as well as fulfill the other provisions appearing at §214(l) of the Act. However, the presence or absence of the waiver is simply not germane to the approvability of the national interest waiver petition. Given that the approval of a national interest waiver petition triggers certain other benefits to an alien beneficiary (see discussion below on adjustment filing procedures) it is counterproductive to require the final USCIS-issued §212(e) waiver approval notice as part of the national interest waiver petition submission.

Furthermore, it should be noted that an alien physician’s ability to adjust to permanent resident status is established at the time the DOS issues the waiver recommendation.\(^{30}\) Yet, through its stipulated requirement of the final USIS waiver approval, the regulations require more stringent and restrictive documentation in order to file a national interest waiver than is required for adjustment purposes.

**Four/Six-Year Durational Limit for Fulfillment of Designated Service Obligation**

The statute stipulates that a physician needs to work for a period of five years in a designated medically underserved area prior to gaining eligibility for permanent resident status. (The sole exception is the three-year service requirement (over a four-year period) for certain grandfathered cases in which the petition was filed prior to November 1, 1998.) However, the regulations go on to stipulate that the required period of mandatory service needs to be completed within a six-year period of time, which, in general, commences when the physician receives employment authorization to work in a designated medically underserved area or a VA facility.\(^{31}\) The statute does not contain any such outermost time limitation for fulfilling the mandatory service obligation.

The regulations then go on to state that the physician bears the burden of showing adequate progress toward fulfilling the required five-year service obligation within the allowable period of time. Specifically, the physician needs to comply with a two-step reporting system. The first step needs to be completed within 120 days of the physician’s second anniversary of service in the medically underserved area and consists of “preliminary evidence” indicating that the physician has completed at least one year of employment.\(^{32}\) The second step occurs within 120 days of completing the full five-year service obligation and is a more extensive provision of evidence indicating that the physician has worked in a full-time capacity for the required period of service for the petitioning employer(s) in the medically underserved area(s).\(^{33}\) Failure to provide suitable documentation establishing fulfillment of this service obligation could be regarded as a material breach so as to result in a revocation of the national interest waiver petition itself.

Furthermore, there are no provisions in the regulations that recognize extenuating circumstances as justifying the need for a longer period of time in order to fulfill the mandatory five-year service obligation.

Given the need and, indeed, the pressure to fulfill the required five-year service obligation within a total period of six years, the commencement date for computing time spent working in a designated medically underserved area or within a VA facility is obviously quite important. Under the current system, the Service computes time creditable toward fulfillment of the five-year obligation as follows:

- For J-1 physicians who have received §212(e) waivers and are working in H-1B status: the date for determining the commencement of the five-year service requirement starts when a physician relocates to the qualifying practice site, *i.e.*, a designated medically underserved area and/or a VA facility;
- For physicians who have not previously possessed USCIS-issued employment authorization

\(^{28}\) 8 CFR 204.12(c)(5) (2001).

\(^{29}\) INA §212(e).

\(^{30}\) INS Memorandum of Paul Virtue, INS Executive Associate Commissioner, Waiver of Foreign Residency Requirement (Feb. 17, 1998).


\(^{32}\) Id. at 53891.

\(^{33}\) Id.
VALUE IN SEARCH OF MEANING: NATIONAL INTEREST WAIVER PRACTICE FOR PHYSICIANS

(e.g., a Canadian physician who enters the United States to take up a job opportunity): the date for calculating the commencement of the five-year service obligation starts when the physician relocates to the qualifying practice site, as above;

- For physicians who have previously held USCIS-issued employment authorization (paradigm: H-1B trainees and aliens previously accorded O-1 status): the date for commencing the five-year service requirement begins on the date on which the I-140 immigrant visa petition is approved.

Duration of Contract

The regulations stipulate that a national interest waiver petition needs to include a signed contract covering the “required period of clinical medical practice” which, as noted above, is for five years. This is regarded as an unduly burdensome, unwieldy, and unfair obligation since medical providers normally contemplate one-year contracts for physicians.

Unquestionably, the burden lies with the applicant to establish a legitimate likelihood and intention of fulfilling the mandatory five-year service obligation. In addition, the law itself provides for mandatory reporting obligations to establish the physician’s progress toward fulfilling his or her five-year service obligation. Furthermore, the failure to fulfill this five-year obligation would be grounds for denying the final approval of permanent residence. In short, the law contains numerous other and more effective review processes to ensure the physician’s fulfillment of the five-year employment service obligation. It seems counterproductive to burden both the employer and the alien beneficiary with a requirement of a five-year contract when this flies in the face of accepted norms of medical employment practice.

In contrast, physicians seeking national interest waiver benefits based on employment within VA facilities need only to present an employment commitment letter, which is conforming to existing employment practices within the VA system. It is somewhat perplexing as to why physicians working within designated medically underserved areas face a process that is at such odds with existing practice realities.

To be valid for national interest waiver purposes, either the contract or the VA commitment letter needs to have been issued and dated within six months of the date on which the petition is filed. Again, this flies in the face of practice reality since the contract or commitment letter would normally have been concluded at the time the parties were pursuing the J-1 waiver approval, which, as noted above, needs to be included in the national interest waiver petition. Since the J-1 waiver process normally takes over six months, in most instances, more than six months would have lapsed between the commencement of the J-1 waiver process and the filing of the national interest waiver petition, which therefore requires the parties to redraft/update the contract as previously concluded.

It should be noted that the regulations do not contain any substantive requirements for the contract. Therefore, for national interest waiver purposes, the parties appear to be free to negotiate at arms length on such issues as noncompete arrangements, liquidated damages, and termination provisions. However, many states have created restrictions on these specific issues as integral parts of their guidelines for their Conrad State 30 Waiver Programs.

Multiple Petition Requirement

A core concept of job offer waiver/national interest waiver practice is that the underlying basis of the alien’s entitlement to permanent residence does not lie in specific services to a specific employer, but rather in the nature of the alien’s overall employment services as favorably impacting national interests. Owing to this essential concept, the Service’s general policy is that a mere change of employment should not trigger a revocation of the immigrant visa petition, provided that the alien continues to work in the endeavor that initially merited national interest waiver approval.

However, the physician-specific provisions of the national interest waiver regulations provide that any change in employer—even if such employer is located in the same designated medically underserved community—requires the submission of a new na-

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34 8 CFR §204.12(b).
36 Id.
37 Id.
tional interest waiver petition, including all of the stipulated supplementary material described above (i.e., attestation statement, etc.). Therefore, the physician not only has to establish a continuation of the underlying services and contributions serving the national interest, but also has to develop a new immigrant visa petition for Service adjudication.

**Adjustment Eligibility**

The regulations provide that the alien physician beneficiary of an approved national interest waiver along with his or her dependent family members can immediately file the adjustment applications whether or not the physician has completed the required period of medical service in the designated medically underserved area or within a VA facility. While this application cannot be approved until the physician has completed the required five-year period of service (or three years for grandfathered cases), the mere filing of the adjustment application provides the physician and dependent family members with the right to the benefits of employment authorization and advance parole.

However, the adjustment filing procedures also need to be correlated with the H-1B service obligations appearing in §214(l) of the Act, which essentially requires that a J-1 waiver beneficiary work for three-years in H-1B status for the petitioning employer prior to gaining eligibility for permanent resident status. Conversely, the nonfulfillment of this H-1B service obligation could represent a material breach of the J-1 waiver so as to lead to a rescission of the waiver and/or ineligibility for permanent resident status.

Therefore, national interest waiver beneficiaries previously holding J-1 Exchange Visitor status and who are subject to the H-1B service obligation of Section 214(l) can file their adjustment applications immediately upon approval of the national interest waiver. In most instances, this filing will take place prior to fulfillment of the §214(l) H-1B service requirement (three years) and the §203(b)(2)(B)(ii) permanent resident requirement (normally, five years). The Service has specifically instructed that physicians can file their adjustment applications prior to their fulfillment of the three-year H-1B service obligation. However, such physicians should not apply for an Employment Authorization Document or in any other manner violate the terms and conditions of their H-1B status until they have fulfilled the mandatory H-1B service obligation of 214(l).

Conversely, the dependent family members face no such restrictions in their eligibility to ancillary benefits to their adjustment filing. Therefore, even if the principal applicant is barred from obtaining employment authorization or advance parole, the dependents should be able to receive these specific benefits.

Once the physician completes the stipulated H-1B service obligation, he or she could then apply for employment authorization. There is an ongoing obligation to work in a full-time (defined as 40 hours per week) capacity for the employer of record as located in the designated medically underserved area for the balance of the required five-year term. However, there is no prohibition or other impediment, should the physician work outside of the designated medically underserved area for periods over and above 40 hours per week.

The regulations create a special filing procedure for adjustment applications. For national interest waiver beneficiaries, the physician shall withhold both the medical examination and the fingerprints from the initial adjustment application packet. However, once the physician fulfills the five-year service obligation, the physician then has a 120-day period to provide the following: (1) confirmation of having worked for the five year period of time which, per regulation, specifically needs to include copies of the alien’s individual federal income tax returns; (2) documentation from the employer confirming full-time employment over this period of time; and (3) medical examination results.

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41 INA §214(l).
42 INS Memo, supra note 40.
44 8 CFR §245.18 (2001).
complex and seemingly contradictory procedural requirements. In addition, they create a five-year service obligation that needs to be fulfilled in order for the physician to gain eligibility for permanent resident status. Conversely, the labor certification approach carries no equivalent employment obligation and, as such, can afford a physician a more time-efficient pathway to permanent resident status. Furthermore, by definition, national interest waivers are restricted to designated medically underserved areas—i.e., those areas suffering from an endemic shortage of physicians so that a test of the labor market invariably fails to produce qualified U.S. applicants.

Given these various disincentives, the issue arises as to when, if ever, a physician would seek to pursue permanent residence under a national interest waiver approach.

A physician would probably want to utilize the national interest waiver approach if:

- The physician is satisfied with his or her position at the petitioning employer so that the physician would not mind working at the employer for, at minimum, a full five-year period of time;
- The physician desires (or is compelled) to relieve the employer of having to actively participate in the immigration case, since the physician can self-petition for a national interest waiver rather than proceeding under the employer’s sponsorship;
- The physician desires to provide employment authorization (and international reentry permission) to the dependent family members as soon as possible.

A physician would probably want to utilize a labor certification approach if:

- The physician wants to obtain permanent residence as soon as possible either to gain the ability to leave the community, or the specific employment position, to undertake other professional opportunities (oftentimes, advanced clinical specialty training), or to be eligible for research grants or benefits only available to permanent residents;
- The physician believes that the employer will be actively and energetically involved in the immigration case, since the employer is required to file the labor certification application and to remain involved throughout the entire petition process.

**CONCLUSION**

At present, there is a major recognition that there are growing shortages of physicians in the United States which, if left unchecked, could result in alarming malfunctions in the access of major segments of the population to physician services. In particular, rural America and various urban pockets, as well as the medical system administered by the Department of Veterans Affairs, have historically faced major shortages of physicians.

The national interest waiver provisions for physicians, appearing a INA §203(b)(2)(B)(ii) were specifically drafted to recognize the national importance of getting physicians to commit to practice situations which historically have been grossly understaffed. Arguably, the implementation of these statutory provisions have injected a number of disincentives and conflicts with the statutory intent, thereby diluting the value of the statute into a less than vibrant shade of meaning.
Section 101(a)(15)(O) of the Immigration and Nationality Act\(^1\) provides for classifying an individual as a nonimmigrant “alien who has extraordinary ability in the sciences, arts, education, business, or athletics which has been demonstrated by sustained national or international acclaim … and who seeks to enter the United States to continue work in the area of extraordinary ability.”\(^2\)

REASONS FOR CONSIDERING THE O-1 FOR A PHYSICIAN

Although seeking the O-1 classification may involve more documentation and preparation than a petition for some of the other nonimmigrant classifications, the O-1 carries a number of benefits and serves as a viable option for some physicians.

Those individuals who have entered the United States in the J-1 classification may be able to obtain the O-1 classification without first seeking a waiver of the two-year home residency requirement.\(^3\) Foreign nationals who have entered the United States in the J-1 classification “to receive graduate medical education or training” are not eligible to apply for an immigrant visa, permanent residence, or a nonimmigrant visa under the H or L classifications until they have met the two-year home residency requirement or have obtained an appropriate waiver.\(^4\) This prohibition does not however bar an individual from applying for an O-1 visa abroad.\(^5\) Please note however that §248 of the INA still bars an individual from changing status from J-1 to any other nonimmigrant classification, including the O-1 status, other than to A or G.\(^6\)

Although the O-1 is a nonimmigrant classification, there is no limitation as to how many years an individual may be in the O-1 status. Moreover, the filing of a labor certification or other preference-based immigrant petition does not affect the approvability of an O-1 petition.\(^7\)

The O-1 classification is underused and does not face a numeric limitation as the H-1B. Only 6,126 individuals received O-1 visas in FY2003 and only 6,026 received O-1 visas in FY2002.\(^8\)

In addition, the O-1 classification does not carry a prevailing wage requirement.

PROCEDURAL ISSUES

In order to obtain the O-1 classification, a petitioner must file Form I-129 along with the O Supplement, and the following required documentation:


\(^{4}\) 8 USC §1182(e); INA §212(e).

\(^{5}\) See 71 Interpreter Releases, supra note 3, at 1376, where Jacquelyn A. Bednarz, former Chief, Nonimmigrant Branch, Adjudications of the legacy Immigration and Naturalization Service responds to an inquiry posed by Bernard P. Wolfsdorf, Esq. discussing J-1 individuals: “You are also correct that there is no other readily apparent bar precluding such aliens from applying for an O-1 visa abroad.”

\(^{6}\) 8 USC §1258; INA §248.

\(^{7}\) 8 CFR §214.2(o)(13).

Evidence to support the claim that the foreign national employee is an “alien of extraordinary ability;”9

Copies of written contracts between the petitioner and the foreign national setting forth the terms of employment or a written summary of the terms of employment;10

Explanation of the nature of the events or activities, the beginning and ending dates for the events or activities, and a copy of the itinerary for the events or activities where the foreign national will be working;11 and

Written advisory opinion from an appropriate consulting entity.12

In seeking O-1 classification, a foreign national may not file the petition on his or her own behalf. There must be a U.S. petitioner: “United States employer, United States agent, or a foreign employer through a United States agent” who can receive service of process on behalf of the foreign employer.13

Where the foreign national will be working for more than one employer at the same time, each employer must file a separate O-1 petition, unless the petition is filed by an agent representing the different employers.14

An O-1 petition may not be filed more than six months in advance of the need for the services of the individual,15 and the petition should be filed with the regional service center which has jurisdiction over the place where the foreign national will work.16

When the foreign national will be working in more than one location, the petition should be filed with the regional service center which has jurisdiction over where the petitioner is located.17 Reported processing times for adjudications of O-1 petitions range from one to three months.18 Premium Processing is available for O-1 petitions.

Initial O-1 petitions are valid for the duration of the event(s) or activities set forth in the petition, but for no longer than three years.19 Spouse and dependents of the O-1 individual may enter under the O-3 classification for the same duration as the O-1.20 The O-3 classification does not carry employment authorization. A foreign national entering the United States in the O classification may be admitted for the period of the approved petition and 10 days prior and 10 days after this period.21 Employment authorization is only available for the validity period of the petition.22

The filing of a labor certification or of an immigrant preference petition should not affect the approvability of the O petition.23 This dual intent however is not expressly recognized; it is a creation of the regulations and not found in the statutory language. With that having been said, however, it may be difficult to obtain an O extension once a Form I-485 has been filed.

Extensions may be sought one year at a time so long as the original petition has not yet expired.24 No additional evidence is required, but the petition must be accompanied by a statement explaining the need for the additional time.25 From a practical point of view, it is most helpful to include a copy of the supporting documentation which was filed with the initial petition because the service centers tend to issue Requests for Evidence regarding it.

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12 8 CFR §214.2(o)(2)(ii)(D).
13 8 CFR §214.2(o)(2)(i). This statute does not require an employer; however, this requirement is solely regulatory.
15 8 CFR §214.2(o)(2)(i).
16 Id.
18 Processing times posted as of April 22, 2004 on the uscis.gov Web site indicate that the California Service Center was working on petitions filed February 26, 2004, the Nebraska Service Center was working on petitions filed March 3, 2004, the Texas Service Center was working on petitions filed March 1, 2004, and the Vermont Service Center was working on petitions filed March 11, 2004.
19 8 CFR §214.2(o)(6)(iii). “Event” is defined in the regulations as “an activity such as, but not limited to, a scientific project, conference, convention, lecture series, tour, exhibit, business project, academic year, or engagement … a group of related activities may also be considered to be an event.” 8 CFR §214.2(o)(3)(ii).
20 8 CFR §214.2(o)(6)(iv).
21 8 CFR §214.2(o)(10).
22 Id.
23 8 CFR §214.2(o)(13).
24 8 CFR §214.2(o)(11).
25 8 CFR §214.2(o)(11)–(12).
For an individual who has entered the United States as an O-1, the employer and—if the petitioner is not the employer—the petitioner, are jointly and severally liable for the reasonable cost of return transportation of the individual abroad to his or her last place of residence prior to admission upon the termination of the individual’s employment unless he or she voluntary resigns.26

**CRITERIA FOR AN “ALIEN OF EXTRAORDINARY ABILITY”**

**In General**

While different standards apply to artists and entertainers in determining “extraordinary ability,” physicians and scientists must also demonstrate “sustained national or international acclaim.” The petition must be submitted with evidence proving that the work in which the foreign national will be participating will be in his or her area of extraordinary ability and that the foreign national meets the criteria set forth in the regulations under 8 CFR §214.2(o)(3).27 Evidence can be in the form of “affidavits, contracts, awards, and similar documentation” which reflect the nature of the foreign national’s achievement.28 Photocopies are acceptable.29

“Extraordinary ability in the field of science, education, business, or athletics means a level of expertise indicating that the person is one of the small percentage who have risen to the very top of the field of endeavor.”30 The individual must demonstrate that he or she has sustained either national or international acclaim and recognition for achievements in the field of expertise.31 Examples of acceptable evidence include receiving major, internationally recognized awards such as the Nobel Prize32 or at least three of the following:

- Membership in associations in the field that require outstanding achievement of their members, as judged by recognized national or international experts in the field or discipline;34
- Published material in professional or major trade publications or major media about the foreign national relating to the work in the field, which should include title, date, and author of such published material and translation;35
- Participation on a panel or individually as a judge of the work of others in the same or an allied field of specialization;36
- Original scientific, scholarly, or business-related contributions of major significance in the field;37
- Authorship of scholarly articles in the field in professional journals or other major media;38
- Current or previous employment in a critical or essential capacity for organizations and establishments that have a distinguished reputation;39
- Command of a high salary or other remuneration for services, evidenced by contracts or other reliable evidence.40

The regulations also indicate that other comparable evidence is acceptable.41

Immigration practitioners have agreed that, despite the standards set forth above, there is no precise science to determining whether an individual qualifies for the O-1 classification. The focus should not be on how many of the above criteria can be met. Instead, the determination is based on the totality of the circumstances and the quality of the evidence submitted which supports the petition. Some practitioners employ what is known as the “wow” standard—that is, ask yourself whether a review of the evidence makes you say “wow.”

**For Physicians**

The criteria for a foreign national physician applying for the O-1 classification are no different than that set forth above for any other “alien of extraordi-

26 8 CFR §214.2(o)(16).
31 8 CFR §214.2(o)(3)(iii).
nary ability.’” The nature of the evidence, of course, will vary and will depend on the field in which the physician has his or her expertise. Evidence for researchers and evidence for clinicians may vary as well. The criteria do favor those physicians who engage in research over those who are pure clinicians. This, however, should not discourage truly extraordinary clinicians from attempting to gain the O-1 classification. Due to the fact that there is no precise science in putting together an O-1 petition for a physician, the challenge for the practitioner is to come up with creative ways of uncovering and presenting the available evidence to the immigration service. In an occupation where the terminology could become highly technical and complex, the job of the practitioner is to explain the significance of the evidence and to paint an accurate and impressive picture of the physician.

In preparing the evidence to support an O-1 petition, the practitioner should make every effort in drawing out all possible information from the foreign national about his or her achievements. Although there are foreign nationals who have no problems in advocating their own extraordinary abilities, there are others who have been raised and schooled in a culture where humility is highly esteemed. As a result, a foreign national may inadvertently overlook or belittle an achievement in his or her record that could make or break his or her case. Working closely with the foreign national has its benefits—in that some are quite savvy in presenting their accomplishments in favorable light and in getting recognized authorities to agree in writing.

The O-1 classification requires an individual to sustain either national or international acclaim and recognition for achievements in his or her field of expertise. In order to set the stage for arguing that the foreign national is an individual of extraordinary ability, one must first define the field of expertise. To advocate that a foreign national is an “alien of extraordinary ability” in medicine would imply that the individual’s achievements rise above the achievements of other physicians in all fields of medicine. A more feasible argument to sustain is to document how an individual has gained expertise in one particular medical field, or medical specialty. In medicine, a wide range of medical specialties exists, and it makes sense first to determine in which specialty, or even subspecialty, the foreign national has expertise. Examples include anesthesiology, cardiology, dermatology, endocrinology, gastroenterology, hematology, oncology, and neurology. There are also examples where the foreign national practices in interdisciplinary specialties or in a particular disease or procedure.

In order to assess properly the achievements of a foreign national physician, a practitioner must spend time in reviewing the foreign national’s accomplishments both in the United States and abroad. The standard is having “sustained national or international acclaim and recognition.” This standard allows employing any accomplishments attained both abroad and in the United States. More often than not, when a physician has entered the United States to further medical education or training in J-1 status, only a few years have been spent in the United States. In this short period of time, there may have been limited opportunities for the individual to prove his or her expertise. The J-1 classification itself also implies that an individual is a student, a trainee, or at least at some early stage in his or her professional career. This, however, should not preclude a practitioner from considering the possibility that the individual may have already developed expertise abroad prior to entering the United States. As a result, the practitioner must also take into consideration any accomplishments the foreign national may have obtained while abroad.

Significance of achievements abroad may not be evident at first glance. In the United States, there is an extensive network of professional organizations in the medical field which serves as means of advancing research in a particular medical specialty and of rewarding those who excel in that specialty. In other countries, however, such professional organizations may not exist, let alone a national network which may bestow national prizes and recognition. In lieu of national awards, practitioners may want to explore how achievements are recognized in a foreign national’s home country. This may include funding from the government: funding for continued research, scholarships to attend international meetings and conferences, and scholarships to pursue

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43 8 CFR §214.2(o)(3)(iii).

44 Id.
education abroad. Other evidence may include special privileges: access to certain prestigious medical facilities, privilege to attend to the medical needs of royalty or the elite class, or representation of the government or a prestigious organization at an international event or conference. An individual’s accomplishment also may be his or her participation in developing cutting-edge technology or procedures in medicine for a country. Acceptable documentation include affidavits and testimonials from experts in the individual’s field of expertise, newspaper articles written about the individual’s work, letters of invitation, and even evaluations from U.S. institutions attesting to the significance of the individual’s particular contribution in his or her country’s medical field.

EXAMPLES OF EVIDENCE FOR MEETING THE CRITERIA

Receipt of nationally or internationally recognized prizes or awards for excellence in the field

In the United States, there is an extensive network of professional organizations for the different medical specialties. Examples include the American Thoracic Society, American Society of Clinical Oncology, American Diabetes Association, American Society of Hematology, Infectious Diseases Society of America, American College of Surgeons, American Academy of Pediatrics, and American Gastroenterological Association. Annual meetings for each of these professional organizations serve as forums for discussing the latest developments in these specialties and for recognizing outstanding achievements for work done in these specialties. Although membership in these organizations predominantly consist of American physicians, conference participants often come from all over the world. Awards at these meetings can be used as evidence of nationally/internationally recognized prizes. Professional honors are bestowed at such meetings and are evidence of excellence in a particular medical specialty.

In addition to the professional organizations in America, there are similar international organizations as well as organizations abroad. The practitioner must discuss with the foreign national physician the professional environment abroad to determine the comparable organizations and honors.

Whether the prize or award is national or international in nature, a practitioner can find additional support for the petition by explaining that the candidate pool is not restricted to students or to young physicians, that the requirements are exceptionally stringent by pointing to numeric figures to underscore the competitive nature of the prize or award where possible, and that there is significant prestige attached to the prize or award including the impact on the individual’s career. It can also be helpful to list past recipients of the prize or award who may have later gone on to achieve stellar, household-name levels of recognition.

Membership in associations in the field that require outstanding achievement of their members, as judged by recognized national or international experts in the field or discipline

In addition to general professional organizations, there are those that are elite and require a certain level of accomplishment for membership. Evidence of membership in such organizations can bolster an O-1 petition. Examples in the United States include the National Academy of Sciences, the American College of Physicians (Fellowship and Mastership ranks), the National Institute of Health, and the governing boards of certain medical societies. The prestige of being a member of such organizations and of comparable organizations abroad should be highlighted by discussing the high standards for admission, the privileges attached to membership, and the exclusivity of such organizations.

Published material in professional or major trade publications or major media about the foreign national relating to the work in the field

Anything written about the foreign national should be evaluated as potential evidence for substantiating the individual’s acclaim and recognition in the field. With the availability of the Internet and other electronic search services, a search of the foreign national’s name could easily bring up articles, references, and other valuable evidence mentioning the contributions and achievements of the foreign

46 A review of Administrative Appeals Office (AAO) decisions of O-1 cases have shown, however, that awards arising out of academic studies cannot be used to meet this criterion because the academic work is merely training for a future endeavor. See Koehler, Lee, & Yale-Loehr, supra note 8, at 109.

45 The authors are indebted to Drs. Susan Shih Huang and David S. Wu for their input and examples of medical societies, publications, and overall practical insight into the medical profession.
national. Other examples of places to look include Who’s Who in Medicine where biographies of certified physicians are included, directories of Board Certified physicians, and the newsletters of hospitals and academic institutions.47

**Participation on a panel or individually as a judge of the work of others in the same or an allied field of specialization**

Physicians who are in the academic setting and who have published a number of articles may be invited to sit on the editorial board of journals or to serve as peer reviewers of articles written by other physicians in their field. Letters inviting physicians to carry out such responsibilities can serve as evidence that the foreign national has served either on a “panel or individually as a judge of the work of others in the same or an allied field of specialization.” Although the regulations only require evidence of participation, recent AAO decisions have indicated that more compelling evidence would be letters pointing out that the basis for the invitation was the physician’s expertise in the field.48 Additionally, documentation highlighting the significance and prestige of sitting on such a panel would further bolster the case.

**Original scientific, scholarly, or business-related contributions of major significance in the field**

Work done by physicians either in research or in practice can be used as evidence of original or major contributions to the field. The significance of medical research can be documented via articles in professional journals and references to such research by others in the specialty. Examples of clinical contributions include developing a new medical procedure, enhancing an existing procedure, or even serving as the lead physician in a complex medical procedure. By explaining the complexity of a procedure, step-by-step, and the dire consequences of a misstep, the significance of the foreign national’s success in completing such a procedure is accentuated.49 Highlighting that few other physicians actually can carry out such a procedure successfully can make the impact of the achievement greater.50 Recent AAO decisions have placed the additional gloss on this criterion as requiring “scientific breakthroughs.”52 Although such a requirement is not found in the language of the regulations, wherever possible, portraying the contribution in such light would no doubt strengthen the petition. The value of the individual’s work can also be documented with articles, affidavits, and testimonial letters from individuals who are knowledgeable in the foreign national’s specialty.

**Authorship of scholarly articles in the field in professional journals or other major media**

Authorship of scholarly articles is another indicia of the major contributions of an individual to his or her specialty of medicine. Even among the professional journals in medicine in the United States, there is somewhat of a pecking order. Among the more prominent and more scholarly publications in the pure medical science side are *Science* and *Nature*. On the clinical side, there is the *Journal of the American Medical Association (JAMA)* and the *New England Journal of Medicine*. One or two publications in these journals will garner much respect among peers in the field. Physicians and peers in this field can attest to this, and their testimonials can bolster the significance of the foreign national physician’s contributions. Where a foreign national’s publications are in journals with less of a widespread audience, such as some of the medical journals for the different specialties, look for a number of articles focused on a specific theme or area of research. Providing information concerning the level of rigor that journals employ in selecting publications can help bolster an O-1 case where the standards are stringent. Practitioners could also include evidence of how often a foreign national’s publication has been cited and the impact of the publication vis a vis ScienceWatch. Likewise, a practitioner could check with the foreign national concerning the different publications in his or her home country if there are no publications in the United States.

**Current or previous employment in a critical or essential capacity for organizations and establishments that have a distinguished reputation**

Close attention should be paid to the resume of a foreign national physician. The hierarchical and competitive nature of the medical profession lends help in underscoring the achievements of an indi-

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47 Seltzer, supra note 42, at 221.
49 Koehler, Lee, & Yale-Loehr, supra note 8, at 111.
50 Seltzer, supra note 42, at 222.
51 Id.
52 See Koehler, Lee, & Yale-Loehr, supra note 8, at 111.
individual. A place with a more competitive postdoctoral training program (e.g., internships, residencies, fellowships) can be used to argue the academic accomplishments of an individual. Recent AAO decisions, however, have questioned whether accomplishments gained in the midst of “training” would be sufficient to meet this criterion. Post-training appointments with universities and teaching institutions such as tenure or hospital appointments such as the chair of medicine or chief of a division with a distinguished medical institution can serve as evidence that the individual ranks higher than his or her peers.

**Command of a high salary or other remuneration for services, evidenced by contracts or other reliable evidence**

In order to argue that one’s salary is a “high salary,” there must be some standard by which the salary is compared. One standard to use is the prevailing wage determined for individuals in this occupation by the U.S. Department of Labor itself. Given the fact that the standard is for past, present, and future salaries, a practitioner should also consider the salaries commanded by the foreign national while abroad. Again, it would be useful to have a standard by which the commanded salary can be compared.

In addition to looking at the salary received or offered to a foreign national, other evidence along the same lines include significant funding received to conduct research. The source of the funding is also important. Needless to say, funding from prestigious organizations which have stringent criteria for funding awards and which are highly competitive will help bolster the O-1 petition. Other evidence includes tangible benefits bestowed upon the foreign national physician such as housing, transportation, tuition, and reimbursements. While evidence of receiving research funding may be discounted as routine, it is always helpful to point out a particularly competitive or unusual source of funding. Recent AAO decisions have discounted funding that was related to research conducted in connection with academic training, but funding based on the expertise of the individual and not merely for prospective work can serve as evidence.

**CONCEPT OF “SUSTAINED” ACCLAIM AND RECOGNITION**

The O-1 classification requires not only that an individual have “national or international acclaim,” but that this acclaim be “sustained.” Although there has not been a specific definition for “sustained,” it logically follows that someone who is relatively junior in the field would not be able to meet this criterion. The O-1 classification is reserved for those who truly possess “extraordinary ability” in their fields. The duration of time in a field, however, is relative to the novelty of the field, i.e., if the field of endeavor is cutting-edge and new, then the amount of time someone has recognition in this field would be shorter than that of someone in a well-established field. As discussed before, accomplishments of the foreign national abroad should also be taken into consideration when determining whether the person has achieved a level of “sustained acclaim.”

**CONSULTATIONS**

O-1 petitions must be accompanied by a “consultation” issued by a peer group of the foreign national. A peer group is defined as “a group or organization which is comprised of practitioners of the alien’s occupation. If there is a collective bargaining representative of an employer’s employees in the occupational classification for which the alien is being sought, such a representative may be considered the appropriate peer group for purpose of consultation.” The consultation must be a written advisory opinion setting forth a description of the foreign national’s abilities and achievements in the field, the nature of the duties to be performed in the United States, and whether the position requires the services of “an alien of extraordinary ability.” In lieu of such an advisory opinion, a consulting organization may also submit a statement indicating that it has no objections with the approval of such a petition. Where the petitioner can establish that no appropriate peer group, including a labor organization, exists, USCIS will render a decision upon the evidence.

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53 Id. at 109.
54 Id.
As a practical matter, in fields such as medicine and other scientific disciplines where there are no peer groups, practitioners can rely on the written statements of experts knowledgeable in the foreign national’s area of specialty. These experts can submit letters attesting to how they are aware of the foreign national’s work, the details and quality of the foreign national’s work, and the significance of the foreign national’s work in the specialty.

**CONCLUSION**

Despite the regulatory language for determining the qualifications for obtaining the O-1 classification, the ultimate test is a subjective one based on the totality of the circumstances. The test for a physician is no different than the test for any other “alien of extraordinary ability.” The challenge, however, is for a practitioner to discuss with his or her client the professional environment in which the foreign national practiced and the foreign national’s professional journey to determine the significance of each of the foreign national’s accomplishments, achievements, memberships, and other professional privileges. Listed above are not exhaustive examples, but are just some ideas to provide guidance and hopefully to trigger more in-depth discussions with one’s client in building a case.

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Most physicians seeking to enter the United States to practice medicine must initially engage in training before they can actually move into private, academic, or other clinically oriented practice areas. This is largely because licensing requirements in each state require training in the United States and, without a license, a visa is not an option. Thus, for the vast majority of physicians, the first step to coming to the United States will be to get accepted into a residency or fellowship program.

The process of getting admitted into a graduate medical training program in the United States is outside the scope of this article. However, for excellent information on this topic, consult the American Medical Association information page on this topic at www.ama-assn.org/ama/pub/category/1554.html. Also, be sure to visit the Educational Commission on Foreign Medical Graduates at www.ecfmg.org. ECFMG is the sole sponsor of physicians coming in to the United States for graduate medical training and plays a role in both the J-1 and H-1B process.

Physicians seeking to enter the United States to engage in graduate medical training can normally enter on either an H-1B or J-1 nonimmigrant visa. The vast majority enters with J-1 exchange visitor visas in a J-1 category specifically carved out for graduate medical training.

J-1 VISAS

Physicians seeking to enter the United States in J-1 status to engage in graduate medical training are subject to strict requirements. The J-1 visa requirements for physicians engaged in “clinical” training are much tougher than the requirements for physicians engaged in “nonclinical” training.

Nonclinical Programs

The Department of State, of course, regulates the J-1 program since it took over that responsibility after the DOS acquisition of the U.S. Information Agency in 1998. DOS’s regulations define the two categories of graduate medical training:

- Physicians who are coming to participate in a clinical exchange program, involving patient contact and care, within a program of graduate medical education or training conducted by accredited U.S. schools of medicine or scientific institutions. The only exchange program sponsor authorized to bring exchange visitors for this purpose is the Educational Commission for Foreign Medical Graduates (ECFMG); and
- Physicians who are coming to participate in a nonclinical exchange program, either with no patient care or contact, or where patient contact is only incidental to the physician’s primary activity of teaching, research, consultation, or observation.

Note that ECFMG must sponsor physicians engaged in clinical training and may sponsor physicians engaged in nonclinical training, particularly if a university or academic medical institution lacks its own qualifying J-1 program or in cases where a physician is coming for a special “advanced short term training” opportunity. The distinction between “clinical” and “nonclinical” can become crucial since physicians seeking J-1s to engage in graduate medical training must pass several examinations that can make entry to the United States a long and cumbersome process.

So what is a “nonclinical” exchange program? DOS regulations explain that universities, academic medical centers, and ECFMG can issue a DS-2019 exchange visitor form to any alien physician coming to the United States for purposes of observation, consultation, teaching, or research. Other exchange visitor categories like research scholar, professor, short-term scholar, and specialist can be used for physicians working in such programs.

The key is whether the primary purpose of the work in the United States is nonclinical. To show that the primary purpose of the program is not

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1 22 CFR §62.27(b).
3 22 CFR §62.27(a).
4 22 CFR §62.27(b)
5 22 CFR §62.27(c).
“clinical,” a physician needs to show that he or she will engage in no patient care or only “incidental” patient care. That means that a physician must show that he or she will only be observing and attending or providing lectures or engaging in research that will not have an impact on patient care. Note that such nonclinical work could include being present when patient care is administered by another physician and even engaging in actual physical contact with a patient as long as it is clear that the care of the patient could in no way be affected by the J-1 holder.6

Any contact with patients must be limited in order to qualify as observation, consultation, teaching, or research purposes noted above. And the DS-2019 issued by the exchange program must specifically note these purposes and whether any patient care will occur.7

Foreign medical graduates seeking to enter the United States for public health and preventive medicine programs can also enter in nonclinical status as long as they do not participate in any direct patient care. In such cases, J-1 responsible officers must attach to the DS-2019 a certificate that states “This certifies that the program in which [name of physician] 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.” 22 CFR §62.27(c)(ii) requires a statement must be appended to the DS-2019 if there is to be any incidental patient care. That language states the following: “(A) The program in which [name of physician] will participate is predominantly involved with observation, consultation, teaching, or research. (B) 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 _____________. (C) The alien physician will not be given final responsibility for the diagnosis and treatment of patients. (D) Any activities of the alien physician will conform fully with state licensing requirements and regulations for medical and health care professionals in the state in which the alien physician is pursuing the program. (E) Any experienced gained in this program will not be creditable toward any clinical requirements for medical specialty board certification.”8

Clinical Programs

As noted above, physicians coming to enter on a J-1 visa to participate in a clinical program as defined by 22 CFR §62.27 must have the sponsorship of the Educational Commission for Medical Graduates (ECFMG),9 a nonprofit private organization charged with ensuring that foreign medical graduates have training on a par with their American-educated counterparts. No other organization is authorized to offer such sponsorship. Clinical training generally includes residency and fellowship programs in primary care and specialty programs, and patient care is more than just incidental.

The ECFMG is charged with a variety of tasks. It processes DS-2019 forms for exchange visitors, evaluates educational and experience credentials, administers tests to ensure physicians have the appropriate skills to come to the United States for graduate medical training, counsels foreign medical graduates, and monitors the graduate training programs where foreign physicians are working. ECFMG charges for its services, and physicians and training programs should plan on the process of getting ECFMG certification and a form DS-2019 taking at least several months.

22 CFR §62.27(b) lists seven requirements for clinical trainees to qualify for J-1 status, and ECFMG’s various documentary and examination requirements are designed to ensure that the regulation is met. Following are the requirements:

1. Have adequate prior education and training to participate satisfactorily in the program from which they are coming to the United States;
2. Be able to adapt to the educational and cultural environment in which they will be receiving their education or training;
3. Have the background, needs, and experiences suitable to the program;
4. Have competency in oral and written English;
5. Have passed either Parts I and II of the National Board of Medical Examiners Examination (or its equivalent or be exempt from those examinations);

9 The ECFMG’s Web site contains a considerable amount of useful information and can be found online at www.ecfmg.org.
6. Provide a statement of need from the government of the country of their nationality or last legal permanent residence;

7. Submit an agreement or contract from an accredited U.S. medical school, an affiliated hospital, or a scientific institution to provide the accredited graduate medical education. The agreement or contract must be signed by both the alien physician and the official responsible for the training.

Exam Requirements

The regulations require an international medical graduate (IMG) to pass Parts I and II of the National Board of Medical Examiners Examination or an equivalent. In fact, the National Board of Medical Examiners and the Federation of State Medical Boards have not offered the NBME exam for many years and now offer a three-step examination called the United States Medical Licensing Examination (USMLE). The USMLE has replaced the NBME, FLEX, FMGEMS, and all other exams previously offered and, since the examination has been offered for more than twelve years, it will be very unusual for practitioners today to see physicians with older examinations.

The first step of the USMLE tests whether physicians can apply their knowledge of biomedical science. The second step evaluates a doctor’s ability to apply medical knowledge. The third step further tests the ability of physicians to apply their medical knowledge to the extent necessary to assure a physician’s ability to practice medicine without supervision. For a J-1 visa, Steps 1 and 2 of the USMLE need to be passed.

Beginning in 1998, ECFMG added an additional testing requirement. Applicants must pass the Clinical Skills Assessment (CSA). The CSA is administered in Philadelphia and Atlanta and is comprised of a battery of mock clinical experiences that tests a physician’s medical skills as well as his or her ability to communicate with patients and other health care personnel. In the years following the addition of this requirement, J-1 admissions to the United States plummeted by more than 25 percent. That was blamed on two major factors relating to the CSA. First, weaker candidates for admission were not passing the exam. Second, unlike the USMLE Steps 1 and 2, which can be taken outside the United States, the CSA must be taken in the United States, and a number of physicians were denied visas to enter.10 The drop has reversed, however, and J-1 admissions are now at levels close to the pre-CSA period. That may be because physicians are better preparing for the examination (including spending more time improving their spoken English skills) and because consular officials are more familiar with the CSA requirement.

Beginning in mid-2004, the CSA examination is being replaced by the new USMLE Step 2 Clinical Skills examination. The exam will normally be referred to by the term “Step 2 Clinical Skills” examination or “Step 2 CS.” That examination is fairly similar to the CSA and will be available not only in Philadelphia and Atlanta, but also Los Angeles, Houston, and Chicago.11

In addition to the USMLE and CSA, J-1 clinical visa applicants need to pass an English examination. The well-known Test of English as a Foreign Language (TOEFL) is used by ECFMG to test an applicant’s English skills. The ECFMG used to administer its own English examination but now only uses the TOEFL.

Three groups of physicians do not need to meet these examination requirements (though state licensing requirements may very well mean that a physician exempt for visa purposes will still have to take the examinations). The exempt physicians include:

- Physicians licensed in a U.S. state prior to January 9, 1977;12
- Physicians who graduated from most U.S. and Canadian medical schools;13 or
- Physicians of “national or international renown in the field of medicine.”14

10 While legacy INS data confirm the drop in J-1 physician admissions in 1999 and 2000, there is no official data available on visa denials for physicians seeking to enter the United States to take the CSA. However, the author of this article discussed the matter with ECFMG officials who confirmed that denials of B-1 visas sought for the purpose of coming to the United States to take the CSA was a serious problem and that ECFMG was working with the Department of State to educate consular officials on the need to take the CSA in the U.S. in order to later qualify for J-1 status.

11 The CSA will be offered until mid-2004 and the results will still be honored even after the Step 2 CS begins. For details on the Step 2 CS, go to www.ecfmg.org.


13 22 CFR §62.27(b)(5).
Statement of Need

The Statement of Need can be provided in the form of a letter that indicates a need in the home or residence country for the physician’s services in the particular training specialty, as well as a confirmation that the physician plans on returning to the country upon completing training in the United States. The wording of the letter should conform to the specific language provided by ECFMG in its application package. The Statement of Need is typically signed by an official in the country’s Ministry of Health or whatever agency is equivalent to the U.S. Department of Health and Human Services. Without a Statement of Need, the physician will have no choice but to pursue an H-1B visa or other method of entering the United States to engage in graduate medical training, since ECFMG will not sponsor a physician lacking the document.15

The ECFMG Certificate

An applicant who passes the exams noted above and whose medical education is reviewed by ECFMG and determined to be adequate can obtain an ECFMG certificate. An applicant must have an ECFMG certificate before ECFMG will issue the required DS-2019 form needed for a J-1 visa application.16 There are other reasons why applicants need the ECFMG certificate including:

- The Accreditation Council on Graduate Medical Education (ACGME) requires residency and fellowship programs to admit only foreign applicants with an ECFMG certificate;
- Medicare reimbursement rules require health care facilities training doctors to ensure that physicians have the certificate; and
- States require the certificate in order to get a training or full license.

The ECFMG certificate has a two-year validity period and can be revalidated by taking the TOEFL exam again. Once an applicant enters the United States in J-1 status, ECFMG will consider the certificate valid indefinitely.

Licensure

In order to participate in graduate medical training in the United States, an applicant not only needs a visa, but the appropriate license as well. Requirements vary from state to state (see appendices in this book), but an ECFMG certificate is a normal requirement. While all three steps of the USMLE are typically required to get full licensure, a temporary license limited to training is available for J-1 visa applicants in most states without having the third step of the USMLE exam.

Section 214(b)

Even if a physician can get into a training program and get ECFMG’s support, J-1s are still subject to §214(b) of the Immigration and Nationality Act, which presumes that an applicant has the intention of immigrating.17 From a practical standpoint, this is normally not a problem, as consular officers do not typically use §214(b) as a basis of denying a J-1 visa for a physician. But it occasionally becomes an issue and cannot be ignored. A physician confronting the problem will typically want to remind a consular officer that, even though he or she may be in the United States for several years in a training program, as part of the application process, he or she has signed a pledge to return to the home country and is subject to §212(e) of the Immigration and Nationality Act which makes remaining permanently in the United States very difficult.

Section 212(e)

Section 212(e) of the Immigration and Nationality Act requires J-1 applicants entering the United States to engage in graduate medical training in a clinical setting to return to their home country or country of last residence for a period of two years.18

14 INA §101(a)(41).
15 22 CFR §62.27(a)(6).
16 Graduates of U.S. and Canadian medical schools accredited by the Liaison Committee on Medical Education (which includes most medical schools in both countries) do not need an ECFMG certificate to get a DS-2019 form though the certificate may be needed to get a license.
17 Section 214(b) of the Immigration and Nationality Act of 1952 states the following:
“(b)—Presumption of Status; Written Waiver 112.
Every alien (other than a nonimmigrant described in subparagraph (H)(i), (L), or (V) of Section 101(a)(15)) shall be presumed to be an immigrant until he establishes to the satisfaction of the consular officer, at the time of application for a visa, and the immigration officers, at the time of application for admission, that he is entitled to a nonimmigrant status under section 101(a)(15).”
18 Section 212(e) of the Immigration and Nationality Act of 1952 reads as follows:
No person admitted under section 101(a)(15)(J) or acquiring such status after admission (i) whose participa- continued
The requirement and the methods for getting the requirement waived are the subject of extensive discussion in this book and will not be covered further here. Section 212(e) is, of course, the major disadvantage of the J-1 over the H-1B visa, and all physicians entering on J-1 status need to carefully consider the requirement before acquiring J-1 status.

### Moonlighting

While it is quite common for residents and fellows to supplement their meager incomes with additional work beyond their training programs, J-1s are prohibited from accepting such work unless their responsible officers designate the work to be part of their training.\(^\text{19}\)

\(^{19}\) The ECFMG issued a memorandum outlining this policy in 2000. The text of the memorandum can be found on the ECFMG Web site at www.ecfmg.org and reads as follows:

The U.S. Code of Federal Regulations governing the Exchange Visitor Program clearly states that the primary objective of the exchange visitor physician’s training in the United States should be to enhance his/her skills in the field of medicine. J-1 visa sponsorship, which is documented by Form IAP-66 and issued by ECFMG, authorizes a specific training activity and associated financial compensation. The final requirement for sponsorship as an exchange visitor physician involves the signing and returning of the white copy of Form IAP-66 to ECFMG. This certifies that the exchange visitor physician understands that he/she “... shall be permitted to perform only those activities described in Items 2 and 4 on page 1 of this form.”

Federal Regulations do not permit activity and/or compensation outside the defined parameters.

The U.S. Code of Federal Regulations governing the Exchange Visitor Program state:

(a) An exchange visitor may receive compensation from the sponsor or the sponsor’s appropriate designee for employment when such activities are part of the exchange visitor’s program.

(b) An exchange visitor who engages in unauthorized employment shall be deemed to be in violation of his or her program status and is subject to termination as a participant in an exchange visitor program.

(c) The acceptance of employment by an accompanying spouse or minor child of an exchange visitor is governed by Immigration and Naturalization Service regulations.

(22 CFR §514.16).

Participation in a structured training program should serve to meet the above objective by strengthening and improving the J-1 exchange visitor physician’s knowledge of American techniques, methodologies and expertise in a particular medical specialty. As J-1 exchange visitor physicians sponsored by ECFMG have a chosen primary objective of graduate medical education, they may receive compensation only for activities that are part of the designated training program. Therefore, work outside of the sponsored program is not permitted.
Length of Training

ECFMG normally issues DS-2019 forms for periods of up to one year at a time with a total of seven years permitted for graduate medical training programs (unless the physician can show exceptional circumstances and can show that the additional training is needed in the applicant’s home country). Physicians must request an annual extension with ECFMG and must include a form I-644 signed by the training program director verifying the physician has been in good standing in the program.

In 1999, the USIA published a Policy Statement that directed ECFMG to not sponsor applicants for any time beyond that necessary for board eligibility. This had the effect of barring many applicants from seeking additional time for prestigious and extremely advanced training programs that typically add a year to the minimally required training.

Changing specialties is also barred by ECFMG after the first two years of training, so physicians need to determine early if the area they have chosen is not ultimately the right decision.

Physicians can typically seek extensions at the end of their seven-year limits in order to study for board examinations. This has often become crucial when physicians are seeking waivers of the home residency requirement and risk falling out of status during the long waiver application process.

“Non-Standard” Programs

ECFMG will sponsor physicians in three types of programs:

- Sponsorship in a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME);
- Sponsorship in programs within a specialty or subspecialty where the appropriate Specialty Board of American Board of Medical Specialties (ABMS) offers a Certificate; or
- Sponsorship of J-1 physicians in programs within a subspecialty that is recognized by the appropriate ABMS Board, as evidenced by a letter from the CEO of that Board.20

ECFMG lists qualifying non-standard programs on its Web site at www.ecfmg.org/evsp/nonstand.html#nonstand.

J-2 spouses

The ability of a J-1 visa holder’s spouse or minor children to work during the term of the J-1 is a significant benefit of J-1 status for many physicians over the H-1B visa. J-2 spouses and children can file an I-765 with a USCIS Service Center after the J-1 has been admitted in J-1 status.21 The J-2’s income from such employment can be used to support the family’s “customary recreational and cultural activities” but cannot be used to support the J-1 principal alien.22 Note that J-2 work authorization can be used for graduate medical training as well. But the couple should be counseled that the J-2 spouse’s completion of a program could be jeopardized if the J-1 completes training too quickly and does not get a waiver of §212(e). That is because the J-2 spouse’s employment authorization is valid only for the duration of the J-1 visa holder’s status and, as soon as J-1 status ends, the J-2 must terminate employment.

20 A discussion of the types of programs DOS will allow ECFMG to sponsor is contained in a September 16, 2002 memorandum discussing a teleconference with participants from ECFMG, the American Council on Graduate Medical Education, the American Hospital Association, the American Medical Association, the American Board of Medical Specialties and the Department of State. That memorandum is reproduced on the ECFMG Web site at www.ecfmg.org/evsp/summary1002.pdf.
21 8 CFR §214.2(j)(1)(v) reads as follows:

(A)—The accompanying spouse and minor children of a J-1 exchange visitor may accept employment only with authorization by the Immigration and Naturalization Service. A request for employment authorization must be made on Form I-765, Application for Employment Authorization, with fee, as required by the Service, to the district director having jurisdiction over the J-1 exchange visitor’s temporary residence in the United States. Income from the spouse’s or dependent’s employment may be used to support the family’s customary recreational and cultural activities and related travel, among other things. Employment will not be authorized if this income is needed to support the J-1 principal alien.

(B)—J-2 employment may be authorized for the duration of the J-1 principal alien’s authorized stay as indicated on Form I-94 or a period of four years, whichever is shorter. The employment authorization is valid only if the J-1 is maintaining status. Where a J-2 spouse or dependent child has filed a timely application for extension of stay, only upon approval of the request for extension of stay may he or she apply for a renewal of the employment authorization on a Form I-765 with the required fee.

22 8 CFR §214.2(j)(1)(v).
Visa Application Procedure

J-1 doctors do not need advance approval from USCIS to be able to submit a J-1 visa application at a U.S. consulate. The chief requirement is to present the normal nonimmigrant visa application, supporting documents (including a DS-2019 form issued by ECFMG), and an application fee.

Since the terrorist attacks of September 11, 2001, the process of applying for a nonimmigrant visa to enter the United States has become much more cumbersome and time consuming. Residency programs around the United States have been reporting problems with applicants not receiving visas in time to start their training programs. This is especially true for applicants from certain Muslim countries (including Pakistan, one of the countries supplying the most physicians to U.S. training programs). Applicants are advised to take these delays into consideration and to apply as early as possible for ECFMG certification and a visa.

H-1B VISAS

Prior to the Immigration Act of 1990 (IMMAct90), the only way for physicians to come to the United States to engage in graduate medical training was to enter in J-1 status. But IMMAct90 dropped this requirement, and for many years now physicians have been able to use the H-1B visa to join residency and fellowship programs. There are several basic requirements physicians must meet to enter in an H-1B status to perform clinical medicine, including the following:

- The physician has a license or other authorization required by the state where the physician will practice;
- The physician has an unrestricted license to practice medicine in a foreign country or has graduated from a foreign or U.S. medical school; and
- The physician has passed the appropriate examinations.23

Examinations

As noted above, a physician needs to have passed one of the required medical examinations:

- Federation Licensing Examination (FLEX) parts I and II, or an “equivalent examination as determined by the Secretary of Health and Human Services”;
- National Board of Medical Examiners (NBME), Parts I, II and III; or
- The United States Medical Licensing Examination (USMLE), Steps 1, 2, and 3.24

For more than a dozen years, the USMLE has been the exclusive examination. Passage of earlier examinations is still recognized, but “mixing and matching” parts of different examinations is not permitted for H-1B purposes.

Note that the Licentiate Medical Certificate of Canada is not equivalent to the FLEX or USMLE for H-1B purposes. Physicians are also required to document competency in English, and passage of the TOEFL will suffice for this purpose.

Licensure

All states require physicians to be licensed to practice medicine including physicians working in residency or fellowship programs. Some states do not permit physicians to sit for USMLE Step 3 prior to engaging in graduate medical training. That creates a “chicken and egg” problem that effectively eliminates the possibility of obtaining H-1B status since USMLE 3 is needed to get an H-1B to enter a graduate medical training program and graduate medical training is needed to take USMLE 3.

The H-1B requirements of IMMAct90 also oblige a physician to show that he or she possesses a state license “or other authorization” in order to perform patient care as well as a full and unrestricted license to practice in a foreign country or proof of graduation from a foreign medical school.25

Note that some states will not issue a license without proof of the issuance of a visa. The circularity problem is avoided in these cases by getting a letter from the state licensing board documenting that the only thing standing in the way of issuing a license is the visa itself. Such a letter has traditionally satisfied USCIS.

Exemptions

Physicians who have graduated from U.S. medical schools do not need to demonstrate passage of

23 8 CFR §214.2(h)(4)(viii).

24 Id.

25 This requirement is now included in the regulations at 8 CFR §214.2(h)(4)(vii)(A).
any of the exams noted above.\(^{26}\) They need only demonstrate that they have a state license. The same applies to physicians who are “of national or international renown in the field of medicine.”\(^{27}\)

**Challenges to Using the H-1B Visa**

From the point of view of the doctor, the H-1B is usually the visa of choice if the goal is to eventually settle in the United States. The avoidance of INA §212(e)’s home residency requirement cannot be overstated for many doctors, particularly those pursuing career paths that don’t easily lend themselves to a waiver strategy.

But getting an H-1B visa is not always easy, and even getting H-1B status is not free from problems.

First, many programs will exercise their discretion and not sponsor physicians for H-1Bs. There are various reasons for this. First, some programs believe that the J-1 is the more appropriate visa category to use for training programs. Others are concerned about problems with the H-1B cap (see the discussion below). Others do not want to assume the various obligations of an H-1B employer and potentially be subject to applicable civil and criminal violations. And others do not feel comfortable with the more complicated H-1B visa application process.

Timing issues can be a major problem in H-1B cases, both before the program starts and after the program ends. Only 65,000 H-1B visas are permitted to be issued per year except in cases where a petitioning employer is exempt. In 2004, the cap was hit for the first time in several years as increased cap numbers reverted to the original statutory limit. An exemption exists for universities and their affiliates as well as nonprofit and government research institutions. Obviously, many residency and fellowship programs are covered, but not all. To date, USCIS has taken a liberal view of the term “affiliation” for purposes of determining whether a residency program is closely enough connected with a university to claim a cap exemption, but practitioners are advised to watch this issue closely.

Even if a physician can get into a program that is exempt from the cap, they may still be “bitten” by the H-1B cap when the program ends. That’s because if a person enters to work in a job that is exempt from the cap and then switches to a job that is not cap-exempt, the alien beneficiary is again subject to the H-1B cap. That is a problem for physicians because their training programs end in the summer, traditionally the period when the H-1B cap is a serious problem. This can frequently result in a significant delay in starting employment since new visa numbers do not become available until October.

Another problem for physicians using the H-1B for training is the six-year limit in the category. If a physician is in a training program that lasts more than six years, the physician may run out of time. It might be possible to pursue a green card during this period of time and that could allow for the possible extension of the H-1B, but qualifying for permanent residency while one is engaged in training can be very problematic, and the physician may not be in a position to apply.

Nevertheless, the H-1B is certainly becoming an attractive option, and over the years, more and more residency and fellowship programs have become comfortable with the application process. The trend of using the H-1B visa instead of the J-1 visa is likely to accelerate, particularly as the physician shortage intensifies and the labor market for foreign medical graduates seeking post-training positions continues to improve.

**CONCLUSION**

Whether a physician seeks an H-1B or a J-1 visa, allow plenty of time to gather documents, enter the United States in visitor status to take necessary examinations, apply for and receive any necessary certifications, apply for the H-1B or J-1 visa, and then wait on potentially lengthy security checks. The process of getting that initial visa could be the most challenging of many imposing immigration obstacles facing a physician seeking to eventually settle in the United States. And making the correct strategy choices at this initial stage of immigration can ultimately determine whether a physician will be able to successfully immigrate to the United States.

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\(^{26}\) 8 CFR §214.2(h)(4)(viii)(B)(2).

\(^{27}\) 8 CFR §214.2(h)(4)(viii)(C).
INTRODUCTION

Representing Foreign Medical Graduates (FMG) and the health care institutions where they work is uniquely satisfying and challenging. These clients provide critically needed, lifesaving care to the medically underserved. In other instances, FMGs are at the forefront of biomedical research efforts that likewise save lives and improve the quality of life. Immigration challenges arise in the representation of FMGs who have entered the United States under an Educational Commission on Foreign Medical Graduates (ECFMG) sponsored J-1 clinical training program because they are uniformly subject to a two-year home residence obligation. These FMGs are obliged to either fulfill their two-year home country requirement or obtain a waiver of that requirement as a prerequisite to obtaining an H or L nonimmigrant visa, or permanent resident status. The numerous laws and policies that govern J-1 waivers for FMGs remind us that immigration law often resembles a labyrinth, and that it is an example “of Congress’ ingenuity in passing statutes certain to accelerate the aging process of judges [and lawyers too].” This article provides an introduction to this complex subspecialty of immigration law and practice, to illuminate a clear path between the need and legal eligibility for waivers of FMGs’ two-year home residence obligation.

FMG WAIVER BASICS

FMGs are eligible for waivers on three bases: (1) anticipated persecution; (2) exceptional hardship to a U.S. citizen or permanent resident spouse or child; or (3) a recommendation from an Interested Government Agency (IGA). An FMG, unlike other J-1 exchange visitors, cannot obtain a waiver of the two-year home country rule based upon a “no objection” statement from his or her home country.

Persecution-Based Waivers

Persecution-based waivers often are unappealing for a number of reasons. First, such waivers require evidence that the foreign national “would be subjected to persecution” (emphasis added). This is a significantly higher standard than the “well founded fear of” persecution burden of proof for asylum applicants (emphasis added). Those granted a persecution-based waiver alone do not obtain a lawful immigration status, but must separately pursue that status. By comparison, those granted asylum are eligible for employment and travel authorization and can apply for permanent resident status after maintaining one year of physical presence in asylee status. At the time of filing for permanent resident status, asylees normally would not pursue a persecution-based waiver, but would generally be advised to pursue their J-1 waiver based on INA §209(c), granted for “humanitarian purposes, to assure family unity or when it is otherwise in the public interest.”

Asylum may be available to those who either were persecuted, or who have a well founded fear of future persecution based upon their political opinions, race, religion, nationality, or membership in a particular social group, e.g., homosexuals and women under certain circumstances. While asylum or a persecution-based waiver is the best option for some FMGs, this type of waiver still demands a set of circumstances that relatively few are able to satisfy. Also, permanent resident applications for asylees are anticipated to take 10 years or more because there is a 10,000 per year limit. Therefore, most FMGs generally only have two meaningful waiver options: an IGA waiver or an exceptional hardship waiver, and these topics are the primary focus of this article.

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2 Id.
3 Lok v. INS, 548 F. 2d 37 (2d Cir. 1977).
4 INA §212(e)(iii).
General Waiver Procedure

Procedurally, all waiver applicants must first request a waiver file number from the Department of State (DOS). This is done by sending a request for a waiver review file number to the DOS Waiver Review Division at 1005 Convention Plaza, Box 952137, St. Louis, Missouri 63101-1200. The request is comprised of self-addressed stamped envelopes, a filing fee in the form of a money order or cashier’s check payable to the “U.S. Department of State” referencing the applicant’s full name and country and date of birth, and a DOS Form DS-3035. If accompanied by a G-28 entering the appearance of attorney, the two self-addressed stamped envelopes may be addressed to the attorney’s office. A preaddressed express courier envelope and airbill may also be included for DOS to transmit a favorable waiver recommendation to the appropriate U.S. Citizenship and Immigration Services (USCIS) service center, as USCIS is responsible for final adjudication of any waiver application. To avoid unnecessarily supplementing the filing later, the package should also include copies of all of the applicant’s Forms IAP-66 and/or DS-2019 documenting his or her entire history of J-1 status, as well as the applicant’s signed personal statement explaining the reasons for not wishing to comply with the two-year residence requirement. The personal statement should explain the change in circumstances that led the applicant to seek a waiver of the two-year home residence obligation agreed upon when signing the J-1 program agreement.

DOS will issue a waiver review file number in a few weeks or months, depending on current processing times, and will send notification of the waiver review file number to the applicant or his or her attorney using the submitted self-addressed, stamped envelope. Thereafter, the assigned DOS waiver file number must appear on every page of all waiver correspondence sent to DOS, whether the correspondence is sent to DOS from the applicant or his or her attorney, from an IGA, or, in the case of a hardship or persecution waivers, from USCIS. Exceptional hardship and persecution waiver requests are first filed with USCIS, and if the required hardship or persecution are established, then USCIS forwards the application to DOS. If DOS concludes that DOS program and policy considerations are outweighed by waiver applicant’s persecution risk or the exceptional hardship to the applicant’s U.S. citizen or permanent resident spouse or child, USCIS almost always concurs that a waiver should be granted, and issues the final approval.

Physicians who receive exceptional hardship or persecution-based waivers, and Physicians who obtain a waiver because of a biomedical research-based IGA waiver from the Department of Health and Human Service (HHS), are immediately eligible to apply for permanent resident status. On the other hand, Physicians who receive an IGA-based waiver because they will work in a medically underserved community or at a Department of Veterans Affairs (VA) hospital, can only obtain H-1B status initially. In fact, their waivers are conditional and they are eligible for permanent resident status only after they have worked in H-1B status at the designated health care

10 Filing fee amount and detailed instructions on initiating a waiver review file with the Department of State are available at http://travel.state.gov/j_faq.html#fee.

11 The denial of a DOS J-1 waiver recommendation request, while not appealable before DOS, does not preclude subsequent applications. Of course, subsequent applications should clearly identify new evidence or the new basis for the waiver application, to avoid risk of perfunctory denial. To file any subsequent applications, the applicant must submit a new waiver review file number request with a new filing fee to DOS, which will reassign the same waiver review file number for the subsequent filing.

Although USCIS must formally approve a J-1 waiver, in reality, DOS determines whether a waiver will be granted, and USCIS virtually always follows the recommendation of DOS. IGA waivers first go from the recommending government agency to be matched with the applicant’s waiver review file at DOS. Exceptional hardship and persecution waiver requests are first filed with USCIS, and if the required hardship or persecution are established, then USCIS forwards the application to DOS. If DOS concludes that DOS program and policy considerations are outweighed by waiver applicant’s persecution risk or the exceptional hardship to the applicant’s U.S. citizen or permanent resident spouse or child, USCIS almost always concurs that a waiver should be granted, and issues the final approval.

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facility for three years.\footnote{Id.} An extensive unsuccessful effort to locate a qualified U.S. worker for the position offered to the FMG is almost always a prerequisite for such an IGA-based waiver.

This article first discusses medically underserved community waiver programs, because more FMGs presently obtain waivers on that basis than any other. It next examines IGA waivers for those working at a VA hospital, IGA waivers based upon biomedical research, and then exceptional hardship-based waivers.

**WAIVERS BASED ON CLINICAL CARE TO MEDICALLY UNDERSERVED COMMUNITIES**

Presently, there are four J-1 waiver programs for J-1 physicians who will provide clinical care to the medically underserved (hereinafter referred to as “community-based waivers”). The largest, the Conrad Waiver Program, authorizes 30 waivers per state annually.\footnote{Pub. L. No. 107-273, §11018(a); INA §214(l)(1)(B).} The Appalachian Regional Commission (ARC), the Delta Regional Commission (DRC), and the Department of Health and Human Services (HHS) also have community-based waiver programs. FMGs who receive community-based waivers must work a minimum of 40 hours per week for three years in H-1B status pursuant to the terms of their waiver agreement prior to gaining eligibility for permanent resident status.\footnote{Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Division C of the Omnibus Appropriations Act of 1996 (H.R. 3610), Pub. L. No. 104-208, 110 Stat. 3009 (IIRAIRA), §622. See also INA §214(l); 8 CFR §214.7(c)(9)(iii). While the October 4, 1999 memorandum from Michael A. Pearson titled “INS on Waivers of Two-Year Foreign Residence Requirement for Foreign Medical Graduates (FMGs)” (hereinafter Pearson memo) indicates that FMGs must in fact start work in H-1B status pursuant to the terms of the waiver within 90 days of waiver approval, some FMGs may be unable to comply with this 90-day rule because of USCIS processing delays on H-1B petitions; DOS processing delays on consular H-1B visa applications; and USCIS’s possible inclusion of H-1B petitions for Conrad 30 waiver recipients in the annual numerical cap on H-1B visas. Therefore, some FMGs rely on their agreement to start work pursuant to the waiver within 90 days of waiver approval, rather than actual fulfillment of that agreement.} This raises licensing, and other significant H-1B issues, beyond the scope of this article.

Federal IGA community-based waiver programs generally are limited to primary care physicians. On the other hand, there has been relative flexibility for specialty care physicians to obtain waivers under the Conrad 30 program. Primary care is federally defined as “general medicine, internal medicine, family practice, pediatrics, obstetrics-gynecology, and general psychiatry.”\footnote{22 CFR §41.63(c)(4)(i). Whether the community-based waiver is obtained under the Conrad 30 Program or a federal IGA waiver program, the physician is required to work 40 hours per week for three years in H-1B status in a federally-designated medically underserved area. INA §214(l)(1)(B).} Some states, however, have expanded their Conrad 30 program to also include specialty medical care. By contrast, in other states even physicians who wish to work as primary care doctors are precluded from a waiver merely because they have specialty training.

There are three types of geographical areas that give rise to J-1 community-based waiver eligibility. First are Health Professional Shortage Areas (HPSA), which are annually defined by a physician-patient ratio that considers physicians providing primary care, dental care, and mental health care. HPSAs are listed on the HHS Web site, [http://bhpr.hrsa.gov/shortage](http://bhpr.hrsa.gov/shortage). Second, Medically Underserved Areas or Populations (MUA/MUP) reflect areas with certain infant mortality rates, and certain percentages of elderly and indigent populations. MUA/MUPs are listed at [http://bphc.hrsa.gov/databases/newmua/](http://bphc.hrsa.gov/databases/newmua/). Third, Mental Health Professional Shortage Areas (MHPSA) reflect areas with a shortage of psychiatrists, and are accessible through the HHS Web site above.

**Conrad State 30 Program**

Guam, Washington, D.C., and 49 U.S. states participate in the Conrad 30 Waiver Program, with Idaho as the only current abstainer. Each state’s specific policies and procedures should be consulted. General requirements for individual states can be found in the Appendix of “Update on Interested Government Agency Waivers for J-1 Physicians,” by Bob Aronson, David Ware, Alison Brown, and Greg Siskind.\footnote{R. Aronson, D. Ware, A. Brown, & G. Siskind, “Update on Interested Government Agency Waivers for J-1 Physicians,” Immigration Options for Physicians 67 (AILA 2004) (hereinafter IGA Waivers article).}
Conrad state waiver programs share the following characteristics:  

- The FMG must work full-time (minimum 40 hours per week providing direct clinical care) for three years in H-1B status for a facility in a HPSA or MUA/MUP.  
- The FMG must agree to begin work at the facility within 90 days of obtaining a waiver from USCIS.  
- The physician must obtain a no objection statement from the home government if the physician is contractually obligated to the home government, i.e., was funded by the government of his or her home country.  
- State waivers may not exceed 30 per state per fiscal year.  

Conrad 30 waivers are distinct from federal IGA community-based waivers in the following ways:  

- Federal IGA waivers are limited to FMGs who will work in primary care, which is federally defined as internal medicine, general/family practice, pediatrics, and psychiatry. States, however, sometimes choose to expand their definition of primary care, which allows for recommendation of waivers to medical specialists. Significantly, even states that embrace the federal definition of primary care and say publicly that they will only do waivers for primary care physicians sometimes do entertain waivers for specialty care physicians if need is adequately documented.  
- Federal IGAs do not allow noncompete clauses in employment contracts between the FMG and their sponsoring facility. Noncompete clauses prevent the FMG from competing with the petitioning institution once the waiver/H-1B agreement ends. State sponsored cases may include employment contracts with such a clause, although some states also forbid them.  
- Facilities seeking federal IGA waivers must confirm they accept Medicaid- or Medicare-eligible patients and indigent uninsured patients. Facilities seeking Conrad state waivers are not necessarily so obliged.  
- IGA waivers must be accompanied by a statement from the FMG confirming that no other IGA waiver request is pending or will be filed during the pendency of the waiver request. Conrad state policies may, or may not, include this requirement.  
- Federal agencies must require evidence of unsuccessful recruitment of qualified U.S. workers. Some states do not require such evidence, but most do.  

Among other areas in which states have developed their own waiver policies or procedures that must be investigated include: pre-application procedures and required site investigations prior to filing; acceptance of MUA vs. HPSA designations; filing deadlines; adjudication timing and patterns; different attitudes towards physicians who are out of status; reporting requirements; and foreign language requirements. These different policies and procedures vary between the states. This reality underscores the importance of studying each state’s specific policies and programs carefully before submitting a Conrad 30 waiver application. The Web sites of the Departments of Health for most states are very informative. Nonetheless, telephone calls to the state contact often clarify many matters.  

The ability of states to entertain specialty and even primary care Conrad 30 waivers is being limited by the shrinking list of HPSAs. Surprisingly, HPSAs are dwindling because of the method by which they are designated, and also because of the effort by the HHS community-based IGA waiver program to assign primary care FMGs to HPSAs to terminate a shortage area’s designation.  

The Appalachian Regional Commission (ARC)  

The ARC, whose policies may be reviewed at www.arc.gov, is a federal IGA program that recommends waivers for various counties in the following states: Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, and the entire state of West Virginia. ARC waivers are only available for primary care practice, and the physician must work in a facility located in a federally designated shortage area for primary care or psychiatric care. ARC will only consider waiver requests upon the written recommendation from the state in which the facility is located. Therefore, individual states often impose their own additional regulations or poli-

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19 INA §214(l).  
20 INA §214(l)(1)(D).  
22 INA §214(l)(1)(A).  
23 Pub. L. No. 107-273, §11018(a); INA §214(l)(1)(B).  
24 IGA Waivers article, supra note 18.
cies. Most notably, although the ARC does not prohibit waivers for FMGs who have specialty training but who will work as primary care physicians, many ARC states will not support a waiver for a physician who has received specialty training. This fact emphasizes yet again the need to investigate potential waiver cases thoroughly before filing.

**HHS Community-Based Waiver Program**

Although HHS historically only served as an IGA for biomedical researchers and research physicians, since December 10, 2003, HHS implemented a program accepting IGA waiver applications based upon clinical care practice in shortage areas. This HHS program is not subject to a numerical limitation, and it adapts to serve high-priority HPSAs: those HPSA communities in greatest need of physicians. Consequently, application requirements for a waiver under this HHS program vary and are subject to change, as HHS re-examines the criteria by which it chooses to identify high-priority HPSAs and the means by which it addresses the needs of high-priority HPSAs. In determining high-priority HPSAs, HHS currently relies on HPSA scores. Presently, HHS also specifies that only particular types of facilities are eligible to apply for a waiver through its community-based waiver program, possibly because HHS may deem these types of facilities as the most capable of meeting the needs of high-priority HPSAs. This HHS program also requires that physicians enroll for standardized credentialing, evidence of the prevailing wage for the physician’s position in the area of the petitioning facility, as well as detailed evidence of recruitment for qualified U.S. candidates. HHS requires that the State Department of Public Health in which the facility is located provide a letter acknowledging the facility’s waiver application. As this relatively new HHS waiver program evolves, it is particularly important to consult the HHS Web site for up-to-date program requirements.

**Delta Regional Authority (DRA)**

The new DRA waiver program, which is similar to the other federal IGA community-based waiver programs, covers more than 240 counties and parishes in Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, and Tennessee. The requirements and procedures for this new waiver program, geared toward primary care physicians and facilities, can be found at www.lexisnexis.com/practiceareas/immigration/pdfs/web354.pdf. Three copies of the DRA waiver application must be simultaneously submitted to the State Department of Health where the petitioning facility is located. The state then has 30 days to either concur with, or object to the waiver request.

**OTHER IGA WAIVERS FOR FMGS**

**The Department of Veterans Affairs (VA)**

VA hospitals provide a coveted IGA waiver option for physicians interested in academic medicine because many VA hospitals are affiliated with leading medical schools. Moreover, although VA-based waivers require full-time employment (40 hours per week) in H-1B status for three years directly with the VA facility sponsoring the waiver, a VA waiver is available to FMGs who will receive what VA facilities internally refer to as five-eighths of a full-time appointment. To dispel confusion that a five-eighths appointment does not qualify as full-time employment for immigration purposes, such sponsored physicians must be able to document their 40 hours of work per week at the sponsoring VA facility.

Such an appointment at the sponsoring VA facility enables the physician to seek a second appointment with a VA-affiliated medical school to teach and/or to conduct research. VA-sponsored waivers are also attractive because the VA hospital need not be located in a medically underserved area. Additionally, VA waivers frequently are granted to specialists. The key to success in the VA-based waivers is documenting extensive, unsuccessful recruitment for qualified U.S. workers. Curiously, the VA will not sponsor a physician in O-1 status for a waiver unless they have first worked, at a minimum, for two years within the VA system.

Procedurally, a VA waiver request is filed with an individual VA facility, which then submits it to the Waiver Review Office within the VA Central Office in Washington, D.C. The VA Central Office generally makes a determination as to whether the VA will act as an IGA on behalf of an FMG within

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25 Id.


28 “VA Staffing Tool Box: Employment of Noncitizens” (May 2002).
four to eight weeks. The VA’s requirements and procedures to act as an IGA are found in the VA Handbook 5005, Appendix J.29

**Health and Human Services (HHS)**

**Medical Research-Based Waivers**

HHS has long had a unique waiver program for FMGs prominent in their field and engaged in critical biomedical research of national significance. Such waivers, which are not readily granted, are requested by universities, corporations, and other biomedical research institutions on behalf of FMGs who generally do not provide patient care, unless that care is completely incidental to their research. Bench research (laboratory-based research), as opposed to clinical investigation, more easily conforms to HHS medical-based research waiver requirements. Importantly, it is the petitioning institution as a whole, and not just a department within the institution, which must request the HHS waiver on behalf of the FMG. The essential requirements for an HHS medical-based research waiver are:

- The FMG must be a truly outstanding academic physician with a strong commitment to research. The focus of his or her research must be in an area of high national priority. The foreign national’s current research achievements must be sufficiently and nationally significant to confirm their capacity to make major scientific/medical contributions in the future. Moreover, the evidence must show that a program or project of interest to HHS would be severely disrupted if the FMG were to depart for two years.

- The petitioning institution must have a high level of research excellence, especially in areas of national priority, and it should be able to demonstrate ongoing funded research projects from federal or private philanthropic sources. It must also show its commitment to creating and supporting a nurturing environment for the FMG’s research.

- A fully competitive search must demonstrate the unavailability of fully qualified U.S. workers. This always involves journal ads, and an explanation of why the petitioning institution’s employees collaborating with the FMG could not assume the FMG’s responsibilities.

Procedurally, an HHS waiver application is initially submitted to the Executive Secretary of the HHS Exchange Visitor Review Board for internal determination regarding the completeness of the application. If sufficient, the waiver application is then forwarded to the National Institutes of Health (NIH) for a technical review, focusing on the intrinsic scientific merits of the research and its relevance to the expressed areas of national interest. The requirements for an HHS medical research waiver can be found at [www.globalhealth.gov/supplementA.shtml](http://www.globalhealth.gov/supplementA.shtml).

It is the prevailing view of experts that FMGs who obtain a waiver on this basis are not obliged to serve three years in H-1B status or even continue employment with the petitioning institution before their waiver becomes final.

**RETTAINING IGA WAIVERS AFTER A CHANGE IN EMPLOYMENT**

FMGs who receive a community-based waiver and who fail to comply with the three-year H-1B, 40 hours per week requirement face reinstatement of the home country rule and even removal,30 unless extenuating circumstances justify a change in employment and the three-year commitment is satisfied.31 Two nonexhaustive examples of such extenuating circumstances are closure of the facility and hardship to the FMG.32 In such circumstances, USCIS has the discretion to authorize a change of employer so long as the FMG can demonstrate a new full-time offer of employment in the same or another HPSA or MUA/MUP for the balance of the three-year term.33 The FMG should ensure that the IGA recommending his or her community-based waiver is informed and consents, if required by the waiver agreement.

A request for extenuating circumstances is made through the filing of a new H-1B petition34 and must include documentation of the extenuating circumstances, as well as an employment contract for employment in another HPSA or MUA/MUP. An application to change facilities based upon hardship must describe specifically how the hardship was caused by unforeseen circumstances beyond the FMG’s control. The agencies recommending community-based waiv-

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ers have formal policies that must be followed regarding the FMG’s transfer from the original petitioning medical facility to another facility.

**HARDSHIP WAIVERS**

J-1 hardship waivers are, simply stated, hard to win. Very hard. The burden of proving the requisite level of hardship is high, and it must arise under more than one scenario. There must be evidence of “exceptional hardship” to the exchange visitor’s permanent resident or U.S. citizen spouse and/or child.\(^{35}\) This exceptional hardship must be way beyond the normal hardship associated with the separation of family members. Moreover, this “exceptional hardship,” which has not been specifically defined, must arise both if the U.S. citizen or permanent resident family members accompany the FMG abroad for two years, and if the U.S. citizen or permanent resident family members were to remain in the United States for two years while the FMG complied with the two-year home country rule.\(^{36}\) Substantial heartache is expected, and alone is never enough to establish the requisite exceptional hardship. In most instances, it is not as difficult to show, for example, that the citizen spouse would suffer exceptional hardship if required to move abroad for two years when there would be significant career disruption. On the other hand, proving that there would be truly drastic consequences if the FMG’s family remained in the United States for two years almost always is a formidable task. Usually, strong documentation of any medical conditions exhibited or potentially exhibited by the permanent resident or citizen family—including proof that adequate medical care is not available in the FMG’s home country and a detailed psychological evaluation if emotional hardship is at issue—are required to establish the requisite high level of hardship if the affected permanent resident or citizen family were to remain in the United States alone for two years. Similarly, the applicant must document any claimed financial hardship due to anticipated separation and the maintenance of two households and if the family relocates abroad for two years.

There is a fairly well developed body of case law that discusses examples of exceptional hardship.\(^{37}\) It must be kept in mind that examples are nothing more than examples, and, in the end, the evidence must clearly establish firmly exceptional hardship, both if the U.S. citizen or permanent resident spouse and/or child goes abroad with the FMG for two years, or remains alone in the United States for two years.

Procedurally, the hardship waiver application is submitted to USCIS on Form I-612, along with extensive supporting documentation, and ideally with a memorandum of law. If USCIS finds exceptional hardship, the application is forwarded to the DOS Waiver Review Division to weigh the exceptional hardship against the general policy of enforcement of the two-year requirement. DOS may or may not concur, and an unfavorable recommendation by DOS to USCIS is likely in a medically-based hardship case where an independent medical review by DOS reveals that adequate health care is available in the FMG’s home country.\(^{38}\)

**CONCLUSION**

Representing FMGs in their quest for a waiver of the two-year home country rule is highly complex, and FMG clients, quite understandably, often are demanding. These clients are exceptionally well informed about waiver requirements and procedures, and clients do not want a lawyer who knows less than they do. The rewards that come from representing FMGs, however, make this a highly desirable practice area. Most FMG cases involve three applications, the waiver, the H-1B, and later, an application for permanent resident status. More importantly, representing FMGs is not only intellectually challenging, but it also brings the immeasurable psychological income that comes with playing a role, however small, in making the world better. And that’s what the practice of law should be about.

\(^{35}\) 8 CFR §212.7(c)(5)(vi)–(vii).


well as the increased medical treatment of a wider array of human conditions (i.e., mental health, various alcohol, drug, and other dependencies, geriatrics, reproductive medicine, etc.) have raised not only major ethical and social concerns, but have also increased our society’s demand for physicians and raised our overall expectation in the ability—if not the outright obligation—of the medical system to address a wide range of human maladies. Related to these advancements in medical practice, people today live longer thereby raising the expectation that an aging population will require ever greater levels of physician services in a system already straining to meet current demand. And as one final note of concern, there continue to be substantial geographic and functional (i.e., practice area) maldistribution patterns in the physician workforce, which has left broad tracts of the United States—particularly rural areas and inner-cities—medically underserved.

Current waiver practice and theory is not only important in the immigration context, but is also relevant to broader national health care objectives. The ultimate importance of J-1 waiver policy is, we would suggest, premised on the following four points: (1) there is an alarming, widespread, and growing shortage of physicians in this country which, if left unaddressed, will compromise our nation’s ability to provide adequate healthcare coverage to the population; (2) the pool of International Medical Graduates (IMGs) provides the single most available source of new physicians; (3) quite importantly, based on empirical data, IMGs display a “gap filling” pattern of practice in that they disproportionately serve the needs of the indigent, medically underserved, ethnic communities, and underserved areas; and (4) for J-1 physicians, a waiver of the §212(e) home residence obligation is an indispensable prerequisite to obtaining permanent resident status so as to enter into medical practice in this country.

Therefore, this article deals with the current state of Interested Government Agency (IGA) waivers to J-1 physicians, and it is an update of an article previously appearing in the AILA Annual Conference Proceedings.

**LEGAL BACKGROUND**

The principal statute governing the admission of IMGs is the Health Professional Educational Assistance Act of 1976 (HEPA), which created substantial new requirements governing the admission and residence of foreign physicians. In particular, the HEPA imposed an across-the-board home residence requirement on all IMGs engaged in clinical training, regardless of their home country, and, in contrast to all other classes of J-1 exchange visitors, eliminated the ability to gain a waiver based on the issuance of a “no objection” statement from the alien’s home country. As codified in the Immigration and Nationality Act (INA), physicians who have entered the United States under an Educational Commission on Foreign Medical Graduates (ECFMG) sponsored J-1 clinical training program are uniformly subject to the two-year home residence obligation regardless of their country of citizenship or last permanent residence. These physicians are obligated either to fulfill their two-year home country requirement or to secure a waiver of that requirement in order to obtain an H-1B or L-1 visa or permanent resident status. There are nearly 9,000 J-1 physicians engaged in programs of clinical

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12 INA §212(e)(i).
13 INA §212(e).
UPDATE ON INTERESTED GOVERNMENT
AGENCY WAIVERS FOR J-1 PHYSICIANS

by Robert D. Aronson, David A.M. Ware, Alison J. Brown, and Greg Siskind

INTRODUCTION

Health care reform and immigration reform are among the major—and most controversial—issues currently on the U.S. political agenda, and the subject of this article deals in large measure with the intersection of these two areas of public concern.

* An earlier version of this article appeared at 2 Immigration & Nationality Law Handbook 134 (2003–04 ed.).

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Within the health care arena, we are witnessing widespread concern that our medical care system is ill-equipped to address emerging medical needs. National health care spending growth is expected to greatly outpace economic growth over the next decade, and is predicted to reach 17.7 percent of the Gross Domestic Product, or $3.1 trillion, by 2012. Through much of the last decade, health policy planning was premised on two suppositions: first, that the United States possessed an oversupply of physicians; and second, that the goal should be to institute a managed care delivery system as the means to better rationalize and economize on the provision of physician services to the public.

At present, this formerly prevailing theory has lost its currency. The widespread belief among health care planners is that the United States faces an emerging shortage of physicians that, if unaddressed, will render the physician workforce incapable of meeting the medical needs of the population. Furthermore, whereas managed care doctrine had postulated that a primary care gatekeeper system would best and most efficiently direct patients to specialty care providers, the current belief is that an initial patient encounter with a medical specialist may be the most cost efficient and effective manner to achieve a satisfactory health care outcome. The steadily expanding nature of medicine’s ability to treat human disease through enhanced pharmaceuticals, genetic engineering, biotechnology advances, advanced research, and clinical breakthroughs as...
training in the United States, which is a prerequisite to medical licensure.15

Unlike other categories of J-1 exchange visitors, an IMG cannot obtain a waiver of the two-year home residence requirement based upon the issuance of a “no objection” statement by his or her home country. Rather, IMGs are eligible for waivers solely on the basis of anticipated persecution; exceptional hardship to a U.S. citizen or permanent resident spouse or child (i.e., anchor relative); or a recommendation by an Interested Government Agency (IGA).16

Regardless of the basis under which a waiver is pursued, the applicant needs to initiate the waiver application process by requesting a waiver number from the Department of State. Once issued, this number then needs to be utilized by the J-1 exchange visitor for all future waiver applications. A J-1 waiver applicant can only have one IGA waiver pending at any given time, although it is permissible to concurrently seek a waiver per an IGA and an exceptional hardship and/or persecution theory.17 If an IGA waiver is denied, the J-1 waiver applicant can subsequently seek a waiver through another IGA.

Procedurally, all IGA waiver requests initially go from the recommending government agency to DOS, which then determines whether it will recommend the request to U.S. Citizenship and Immigration Services (USCIS) for approval. Previously, waiver requests were reviewed by the U.S. Information Agency (USIA) without a filing fee. In 1998, USIA instituted a filing fee for all waiver requests, and in October 1999, USIA was dissolved and the exchange visitor functions were transferred into DOS, thereby establishing the current track of first going through DOS and then USCIS.18

Exceptional hardship and persecution waiver requests are filed with USCIS. USCIS makes the initial finding as to whether the waiver applicant has met his or her burden of establishing either exceptional hardship to a U.S. citizen (USC) or lawful permanent resident (LPR) spouse or child (i.e., the anchor relative) or persecution to the applicant. If USCIS makes such a finding, it then forwards the waiver request to DOS, which will balance the intrinsic merits of the waiver application with the public policy of the J-1 Exchange Visitor Program of compelling the return of the alien to his or her home country. This entire issue of the degree to which DOS should defer to an initial USCIS determination of exceptional hardship or persecution is a matter of ongoing discussion between AILA and DOS.19 If DOS issues its own waiver recommendation, the waiver will then be sent back to USCIS for final adjudication, which almost invariably will endorse the decision of DOS.

The IGA waiver strategy has been most often used by IMGs because the criteria for eligibility are generally based on more objective and manageable factors than for hardship and persecution waivers. This article will therefore focus primarily on IGA waivers for physicians.

INTERESTED GOVERNMENT AGENCY RECOMMENDATIONS

The various IGA waiver programs have changed over the years and often have proven to be controversial. For several years, the Department of Housing and Urban Development (HUD) and the Department of Agriculture (USDA) served as IGAs for physicians seeking to relocate to inner-city and rural areas, respectively. Each of these agencies has terminated its program.20 Conversely, the Department of Health and Human Services (HHS) recently initiated a waiver program for clinical physicians as a supplement to its pre-existing program for academic

16 INA §212(e)(iii).
17 “CSC Minutes for 8/7/02,” posted on AILA InfoNet at Doc. No. 02091940 (Sep. 19, 2002); “CSC Minutes for 1/29/03,” posted on AILA InfoNet at Doc. No. 03020441 (Feb. 4, 2003).
biomedical researchers,\(^{21}\) and the Delta Regional Authority (DRA) has instituted a waiver program focused on its own specific geographic area.\(^{22}\) In addition, the annual waiver allocation granted to the individual states through the Conrad Waiver Program has been raised from 20 to 30 waivers, and a number of states have either initiated, expanded, or otherwise modulated their own Conrad 30 waiver programs.\(^{23}\) (See chart appearing as an Appendix to this article). In short, there has been significant change in IGA waiver practice and policy during the last several years.

Essentially, there are three paradigms for IGA waivers for IMGs: (1) community-based medical service in a medically underserved area; (2) employment directly within a federal facility (i.e., the Veterans Administration); and (3) academic research of perceived national significance.

**PARADIGM #1: MEDICALLY UNDERSERVED COMMUNITY-BASED WAIVER PROGRAM**

J-1 waivers based on service in medically underserved communities are standardized for the most part through federal regulations. Before 1996, there were sharp statutorily-based differences in waivers recommended by a state as opposed to a federal IGA, as well as among the various federal IGA programs. Changes to the INA\(^{24}\) in 1996 set a uniform requirement that all IMGs who receive waivers through either a federal or state IGA program, other than researchers receiving a recommendation by HHS, must fulfill a three-year service requirement in H-1B status prior to gaining eligibility for permanent resident status or an immigrant visa.\(^{25}\) The rationale for exempting non-clinical HHS physicians is that they are regarded as researchers rather than physicians “engaged in the practice of medicine.”

While there are several important distinctions between the waiver programs open to federal IGAs and the states under the Conrad 30 Program, the issue of overriding importance concerns the flexibility to pursue waivers for specialty care physicians. For physicians working in designated medically underserved areas, federal agencies are limited to issuing waiver recommendations solely to primary care practitioners, defined as: general medicine, family practice, internal medicine, pediatrics, obstetrics-gynecology, and general psychiatry.\(^{26}\) In contrast, there is no such limitation placed on the states, and, indeed, most states now extend waiver eligibility to varying extents to specialty care physicians.

If a physician gains an IGA waiver through either a federal or a state agency, the physician becomes obligated to work strictly on a full-time (40 hour) basis for three years in a designated medically underserved area. Specifically, it is not enough that the physician will serve a patient population located in a designated medically underserved area; rather, the law has essentially created a “physical presence” test which requires the employing facility to be physically located in an area which has received federal designation as a medically underserved area.\(^{27}\)

When considering eligibility of a particular geographical area, there are three schemas of medical underservice. First, there is a system based on a strict ratio of physicians to the area’s population. In this instance, if the physician-to-patient ratio is 1:3500 or less, an area can qualify as a Health Professional Shortage Area (HPSA). (There are some limited exceptions for HPSA designation if there is a


\(^{22}\) Information regarding the DRA is available at www.dra.gov.


\(^{25}\) It should be noted that this is a regulatory, rather than statutory requirement, set out at 8 CFR §212.7(c)(9)(iii).

\(^{26}\) 22 CFR §41.63(c)(4)(i).

\(^{27}\) INA §214(l)(1)(D).
physician: patient ratio of 1:3000.) HPsa designations, which are made only for primary care, dental, and mental health, are updated annually in the Federal Register, but are currently available in the most updated form from the HHS Web site. Second, the system of Medically Underserved Areas or Populations (MUA/MUP) accounts for additional factors to determine medical underservice, specifically infant mortality rates, percentage of elderly population and indigent population. Third, certain communities or areas receive Mental Health Professional Shortage Area (MHPSA) designation so as to designate a shortage of available psychiatrists.

Health and Human Services Waiver Program

The Department of Health and Human Services (HHS) is the lead federal agency overseeing this nation’s healthcare system. For years, HHS has served as an IGA for research physicians and biomedical researchers performing cutting-edge studies of national importance. Conversely, HHS historically has refrained from serving as an IGA for physicians rendering clinical service in designated medically underserved areas.

On December 19, 2002, HHS announced its program to serve as an IGA for clinical physicians. The HHS program that was released was one that largely replaced the USDA program as well a HUD program for underserved urban communities that closed in 1996. The HHS program was described at length in our June 2003 health care immigration newsletter.

In October 2003, HHS closed the program down temporarily. Officials at HHS informed the public that the reason for the shutdown was to make minor adjustments and that it would be reopened shortly after that. The program did, in fact, reopen, in December 2003, but with new restrictions so drastic that most places in the United States previously eligible for HHS waivers will no longer be eligible.

The new rules added several key restrictions:

- Medically Underserved Areas no longer qualify, and only Health Professional Shortage Areas with a score of 14 or higher can qualify.
- Private employers can no longer apply for waivers.
- Only qualified community health centers, rural health clinics, and clinics serving Native Americans and Alaskans can sponsor physicians.

An analysis conducted for Siskind Susser’s Visalaw.com Web site reviewed the impact of the changes in several key states. Most states saw significant reductions in the number of counties which could qualify for waivers. Some, like Delaware and Iowa, are basically shut out all together.

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<tr>
<th>State</th>
<th>Previously Eligible Counties</th>
<th>Currently Eligible Counties</th>
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<tr>
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<td>Wyoming</td>
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A number of State departments of health have expressed concerns that they had made significant changes to their State 30 program based on the assumption that a viable HHS waiver program would continue to exist. Some felt that the new rules would seriously hamper their efforts to attract primary care physicians to their states as J-1 doctors will increasingly look at nations other than the United States when their residency programs end. Recently, the American Hospital Association weighed in as well urging HHS to reverse the changes. The new HHS rules mirror similar rules that apply to the National Health Service Corp program that provides student loan repayment benefits to American doctors willing to work in underserved communities. Those rules were dramatically stiffened several years ago in re-

28 Criteria for determination of Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUs) are published at 42 CFR Chapter 1, pt. 5 (1993).
29 Available at http://bhpr.hrsa.gov/shortage.
response to budget cuts at HHS. However, HHS does not provide any funding for J-1 physicians working in underserved communities, so the logic of having the same restrictions for foreign doctors is not immediately apparent. HHS had 43 applications filed prior to closure of the program. The new rules are so restrictive that many predict that, at most, only a few dozen cases will be approved each year under the program.

Assuming that a facility could somehow still qualify, there are still four main issues of concern with the HHS waiver program: (1) the level of coordination between other IGAs and HHS in adjudicating a waiver application; (2) a stipulation that the physician’s position commence within 12 months of the conclusion of his or her primary care medical training; (3) the requirement that the physician must have a medical license at the time the application is submitted; and (4) the commitment of HHS to clinical care needs given the Department’s traditional concentration on research physicians.

First, it is somewhat unclear as to the level of coordination required with other IGAs for HHS to recommend a waiver. The regulations seem to imply that HHS will only recommend a waiver if the state’s Department of Health has either failed to issue a waiver under its own program or has used up its annual allotment of 30 waivers. The problem here is that the two programs may and in many cases should have complementary goals. The states have the latitude to recommend J-1 waivers to medical specialists whose employment is deemed to serve particular medical needs of the state. HHS as a federal agency does not have this latitude. Rather, its waiver program is restricted solely to primary care practitioners.

However, by conditioning HHS waiver adjudications on whether or not the state has exhausted its full allotment of waivers, the concern is that the states may feel themselves forced to recommend waivers to primary care physicians rather than marshalling their limited number of waivers to those physician placements of maximum benefit to the state, which could include medical specialists. If the states could have the certainty that primary care physicians were being adequately served by HHS, they could then use their own waiver programs in a manner of maximum utility to their own health coverage interests. Conversely, given the uncertainty on HHS action, many states may need to protect their own baseline needs by recommending waivers to primary care physicians rather than constructing a federal-state partnership intended to place adequate physicians in designated medically underserved areas of maximum benefit.

In addition, this deference by HHS to the states will, in certain instances, inject a level of delay and duplication, particularly in those states which announce their waiver decisions late in the fiscal year and minimize the independent interest of HHS in facilitating the relocation of physicians to medically underserved communities.

While it may be meritorious to include a consultation requirement with the states in which HHS would only act on a J-1 waiver pursuant to the full knowledge and acquiescence of the state, it seems counterproductive to have an inflexible policy of deferring all HHS waiver decisions until the state has completely used up its waiver allotment or affirmatively declined to issue a waiver.

Second, the HHS program creates a requirement that the physician’s position commence within 12 months of the conclusion of his or her primary care medical training. The stated rationale is to ensure that an HHS waiver beneficiary has current experience in primary care medicine, and it seems to also be grounded in a desire to ensure that medical specialists do not use the HHS waiver program as a subterfuge to practice specialty medicine under a program designed for primary care practitioners. However, this 12-month window is of concern for the following reasons: first, it does not account for physicians who have departed the United States and are practicing primary care medicine abroad; second, given the steadily lengthening adjudication times within the federal agencies, it becomes problematic for a physician and/or the employer to meet this 12-month deadline; third, most specialty care physicians need first to complete programs in primary care medicine and it seems counterproductive to eliminate this pool of candidates from HHS waiver consideration; fourth, under the HHS regulations, the definition of primary care is severely limited so as to eliminate certain initial encounter medical disciplines, such as geriatric medicine and hospitalist; and fifth, this mechanistic 12-month window does not provide for any flexibility in determining whether a physician’s experience as a practitioner would well serve the primary care needs of a community.

Third, the HHS regulations require the physician to possess a medical license at the time the waiver is filed. Unquestionably, a physician has the burden of
establishing licensure eligibility. However, there are states which condition issuance of a license on obtaining visa status, and physicians seeking practice opportunities in such states would seem to be barred from HHS waiver consideration. Therefore, a more appropriate standard would be for the physician to hold licensure at the time that the employment is to commence, and not at the time that the waiver application is filed.

Fourth, for years, HHS has served as the lead IGA for research-oriented physicians, and the Department has presumably through its Waiver Review Board gained considerable expertise in determining the research capabilities of applicants for J-1 waivers. The Interim Rule designates the Waiver Review Board as the ultimate arbiter of waiver applications filed for clinical physicians as well, although there seems to be provisions for incorporating members onto the panel with background knowledge and sensitivities to the clinical practice of medicine. As such, it is simply a matter of common sense that the Waiver Review Board be empaneled with expertise in the importance of clinical practitioners to medically underserved communities.

U.S. Department of Agriculture

The USDA initiated its waiver program in February 1994, and for years, this Department served as the primary IGA for physicians seeking to relocate to rural communities. Throughout its activity, USDA exhibited certain conflicts in its attitude toward its waiver program, generally citing its inability to adequately monitor the fulfillment by its waiver beneficiaries of their obligations and a perceived pattern of practicing specialty care medicine rather than primary care. In addition to specialty care concerns, in the aftermath of the 9/11 tragedy, the USDA recurrently cited its concerns that there was no mechanism in place to fully ensure that its waiver beneficiaries were not security threats to this country.

On March 1, 2002, the USDA announced its termination of its waiver program. It initially returned pending waiver applications but eventually agreed to adjudicate them. Waivers that had been recommended for approval were unaffected, although USDA did condition its final sign-off on the completion of a background security check.

Appalachian Regional Commission

The ARC has the longest record of recommending IGA waivers for IMGs. The ARC’s jurisdiction covers counties in the following states: Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, and all of the State of West Virginia.

The ARC limits waivers to primary care practice—defined as general or family practice, general internal medicine, pediatrics, or obstetrics/gynecology. In addition, the physician needs to practice on a full-time basis in a facility physically located in a federally designated shortage area for primary care or for psychiatric care.

The ARC waiver program involves a close federal-state partnership. The ARC has developed broad waiver guidelines that the individual states thereafter implement and, to a certain degree, customize in light of their own stated needs. The federal co-chairmen of the ARC will only consider waiver requests upon the written recommendation from the governor of the state in which the facility is located. Individual states often impose their own additional regulations or policies, which can make the waiver process quite involved and lengthy. For example, the ARC does not prohibit waivers for IMGs who have engaged in specialty medical training, but almost half of the states in its jurisdiction have disqualified physicians who have received specialty training. To meet the baseline criteria for an ARC waiver, the following key conditions of ARC’s waiver program must be met:

- In addition to containing all the clauses and attestations required by DOS regulations, the employment contract must contain ARC’s $250,000 liquidated damages clause, verbatim.

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33 “Update from USDA Withdrawal from J-1 waiver program,” posted on AILA InfoNet at Doc. No. 02030671, (Mar. 6, 2002).


35 ARC’s policies may be reviewed at www.arc.gov/index.do?nodeId=272.
• The petitioning facility must be a Medicare and Medicaid certified hospital or primary health care clinic that accepts medically indigent patients on an open, nondiscriminatory basis, and must physically post this policy conspicuously in the waiting room at the proposed practice site.

• The petitioning facility’s attempts to recruit U.S. physicians must have been conducted within, and sometimes, throughout, the previous six months, and must at a minimum have included advertisements published in nationally circulated newspapers or medical journals, and documentation that job opportunity notices were placed at all medical schools in the state in which the petitioning facility is located.

• Petitioning facilities other than community health centers and other federally qualified health centers filing a waiver request on the basis of a HPSA population designation must provide evidence of the facility’s three-year history and continuing intentions to serve the designated population.

• The percentage of patients provided services at reduced or no charge is equal to or higher than the percentage of such patients in the state.

• The percentage of Medicare patients is not less than 80 percent of the percentage of Medicare patients in the state.

• The percentage of Medicaid patients is not less than the percentage of Medicaid patients in the state.

• The IMG must also demonstrate that since receiving the J-1 visa, he or she has not otherwise been out of status for more than six months as of the date on which the ARC reviews the waiver request. However, the ARC follows USCIS and DOS policies that a J-1 visa holder with a “D/S” or “duration of status” notation on his or her I-94 card is not out of status until USCIS or an immigration judge makes a finding that he or she is out of status.

**Conrad State 30 Program**

Initially, under the provisions of INA §212(e), only federal agencies could serve as IGAs. Conversely, state agencies have traditionally lacked the authority to recommend waivers of the home residence obligation. However, within the physician sphere (as opposed to non-physician J-1 waiver cases), the states have been granted a numerically limited ability to serve as IGAs, presumably in light of their familiarity with their own physician coverage needs and the historic role played by the states in the regulation of physicians.

This expansion of IGA authority to the Departments of Health of the various states was spearheaded by Senator Kent Conrad (D-ND), dating back to provisions passed in 1994 which temporarily amended the INA to authorize state or “equivalent” Departments of Health to directly act as IGAs in support of waiver requests of petitioning facilities located in the state. The Conrad legislation also amended the INA to provide the fundamentals for all state IGA waiver programs, which then included:

• The IMG must agree to work full-time for a facility in a HPSA or MUA/MUP for at least three years in H-1B “specialty worker” nonimmigrant status.

• The IMG must agree to begin work at the facility within 90 days of receiving approval of the waiver by legacy INS.

• The physician must obtain a no objection statement from his or her home country if contractually obligated to his or her home country.

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36 As stated above, states often impose additional requirements in the case of ARC waivers; for example, a participating state may require recruitment conducted throughout the six-month period prior to filing the waiver request.


38 INTCA created a new INA §214(k), 8 USC §1184(k), which provided the basic prerequisites for state waivers. Confusingly, in extending these requirements to most federal waivers for IMGs, IIRAIRA re-designated former INA §214(k) as §214(l), without re-designating the previously existing §214(l); therefore, this section is currently found at the first, not second INA §214(l).

39 “State” is defined at INA §101(a)(36) to include the District of Columbia, Puerto Rico, Guam, and the Virgin Islands of the United States. DOS considers these non-state jurisdictions to be “equivalent” and accepts applications for the “State 30” program for them. A list of state or equivalent Department of Health contacts may be found at [http://travel.state.gov/StateHealthSignatories.html](http://travel.state.gov/StateHealthSignatories.html).

40 See supra note 25, for a discussion of this issue.

41 USIA regulations clarified that to be “contractually obligated,” an IMG must have been funded by the government of his or her home country. 60 Fed. Reg. 53123 (Oct. 12, 1995); current DOS regulations at 22 CFR §41.63(e)(2) and
State waivers were not permitted to exceed 20 per state per fiscal year.

In 1996, Congress passed legislation that extended authorization for the Conrad State program for another six-year period until June 2002 and created greater uniformity between the federal and state waiver programs. The primary statutory distinction is that there is a numerical waiver limit placed on the states while there is no comparable numerical limit imposed on federal agencies. Furthermore, the states implicitly have the flexibility to recommend waivers to medical specialists as opposed to the restriction limiting federal IGAs to primary care physicians.

As a result of the Department of Justice authorization bill, the state-based waiver program has been extended for an additional two years, through June 1, 2004, and the annual waiver limit of the states has been raised from 20 to 30. In addition, the states were granted retroactively an additional 10 waivers during 2002 for cases originating in that fiscal year. Legislation to extend the State program until 2009 is expected to be introduced shortly.

While there are a great number of identical features between a federal IGA and a Conrad 30 waiver, there are some important distinctions, which should guide the practitioner in making strategic decisions on behalf of a client, including:

- Federal waivers are limited to IMGs who are trained in and agree to provide primary care. Conversely, states have the latitude to define primary care and to recommend waivers for medical specialists if they believe there is a need for specific medical specialties.
- DOS regulations prohibit federal agencies from including non-compete clauses in employment contracts between the sponsoring facility and the IMG. By contrast, employment contracts may include such a clause in state sponsored waivers.
- Federal agencies must require a statement from the facility confirming acceptance of Medicaid or Medicare eligible patients and indigent uninsured patients. States are not obligated to require this statement.
- Federal agencies must require a specific HPSA or MUA/MUP identifier number, county code and census tract or block numbering area number, or the ZIP code of the petitioning facility. States may accept more general evidence that the facility is located in a federally designated HPSA or MUA/MUP.
- Federal agencies must require a statement from the IMG confirming that no IGA waiver requests are pending with other federal or state agencies, and that no IGA waiver requests will be filed with other federal or state IGAs during the pendency of the waiver request being filed. States do not necessarily require this statement.
- Federal agencies must require evidence of unsuccessful recruitment efforts for U.S. physicians. States are not obligated to require evidence of unsuccessful recruitment.

The waiver policies for each state to implement the Conrad State 30 J-1 waiver program are developed in different ways. For most states, a state Board of Health Commissioner establishes the program policies but usually works closely with the state’s primary care office, and in many states, the primary care office develops the policies. States with waiver programs have additional control in addressing the problem of physician maldistribution. However, either due to budgetary or human resource constraints, or institutional reluctance, not all states have waiver programs.

Primary Care

States may, but are not required to, adopt the federal definition of primary care. Most state programs follow the federal model of defining primary care as: family or general practice, general internal medicine, obstetrics/gynecology, general pediatrics, and psy-

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§41.63(e)(3)(vii) do not specifically define “contractually obligated” but utilize the language “otherwise contractually obligated” to imply a contract in addition to the normal promises made by an IMG.

42 IIRIRA at §622 amended INA §212(e) and former INA §214(k).

43 On November 2, 2002, Pub. L. No. 107-273 changed the Conrad State Waiver program from 20 to 30 waivers per State.

44 Id.


46 The Appendix to this article contains a comprehensive summary chart of Conrad 30 waiver programs.

47 Currently, several states that formerly did not have programs or that had stopped their programs, have begun new ones—including Kansas, Montana, Oregon, Texas, and Wyoming. Idaho still does not have a program.
chiatry. However, other states, while ostensibly limiting their waiver programs to primary care practitioners, either expand or contract their definition of primary care.

It has, though, been the experience of the authors that even in states maintaining stipulated definitions of primary care disciplines, it is sometimes possible to obtain waivers for medical specialists who provide primary encounter services, particularly in a medical area of pronounced medical concern (i.e., infectious diseases/AIDS treatment or respiratory diseases in inner city communities), or who split their practices between primary and specialty care medicine. (Note: Most specialty care physicians are American Board Eligible in a primary care discipline.)

Specialty Training

Federal agencies and states are similar in that both have latitude in developing policies regarding IMGs who have trained in a non–primary care specialty. The definition of specialty medical disciplines varies as a consequence of the latitude in defining primary care. Also, some specialty practice areas, such as nephrology, cardiology, oncology, hematology, and neurology, require a physician to have first completed a residency program in primary care/internal medicine, whereas other medical disciplines (e.g., anesthesiology and surgery) do not require training in primary care medicine.

The states have the latitude to define their eligibility standards for physicians who have completed specialty medical training. Whereas some states will favorably adjudicate waiver applications for specialty trained physicians who are being employed in primary care positions, other states hold that completion of specialty training disqualifies a physician from waiver consideration. The apparent rationale behind a prohibition on specialty training is that such training indicates either a lack of commitment to the practice of primary care or an unacceptably high temptation to violate the state’s waiver policies by practicing specialty care medicine, which is normally more remunerative than primary care practice.

Contract Terms

Federal agencies do not allow non-compete clauses that prevent physicians from competing with the petitioning facility upon completion of the three-year commitment. The rationale for the prohibition is to promote the permanent relocation of the physician in the underserved area. Although states are not required to prohibit such clauses, several states have incorporated such non-compete clauses into their waiver programs.

Other states have developed certain special contractual requirements and provisions as part of their waiver programs. For example, certain states require contractual terms of employment in excess of three years or impose liquidated damages provisions, normally of $250,000.

Specialty Practice

In contrast to federal IGAs, the states have the flexibility to recommend waivers to medical specialists. However, many states have chosen to limit their waiver programs solely to primary care physicians, while others place special restrictions or grant less favorable consideration to waiver applications for specialists. For example, some states will consider specialists only if the petitioning facility and patient population can document a special, critical need for the IMG’s specialty and unsuccessful recruitment for a U.S. physician. States may establish the standard by which they will consider specialty practice such as “unusual need” or “extraordinary circumstances.” Some states have the additional contingency that they will consider specialists only if the allotment of 30 waivers is not exhausted.

Medically Underserved and Population Designations

There is a general tendency to regard MUA designation as a less precise and less compelling measure of medical underservice, and as a result, some states do not approve waiver applications for facilities located in MUAs. (The MUA listings are also less frequently updated which further erodes its credibility as a measure of underservice.) While the majority of states accept waiver applications from facilities located in either HPSAs or MUAs, a substantial minority limit their waiver programs solely to facilities physically located in HPSAs.

Recruitment Requirements

Federal agencies must require evidence of recruitment for U.S. physicians. States are not subject to this requirement, although the vast majority of states require evidence of some kind of recruitment. Acceptable evidence of recruitment efforts may include dated copies of advertisements in medical journals and letters to state medical schools.

Specifically, most states require evidence of recruitment during the six-month period before filing of a waiver application. However, some states stipu-
late required periods of recruitment which can run anywhere from three months to a year.

Also, directly related to the recruitment requirement, various states require (or at last favorably recognize) retention plans indicating both short- and long-range plans for retaining the IMG upon completion of the minimum three-year commitment. As a general observation, retention plans are particularly important for waiver requests filed for specialty care physicians, given the general bias of most state waiver programs toward primary care.

Additional Variations in State Programs

There are a number of other areas in which the states have the latitude to develop their own waiver policies or procedures, including:

- Pre-application procedures and required site investigations prior to filing the waiver application.
- Establishment of filing deadlines. In fact, some states open their application period before the commencement date of the federal fiscal year while others simply hold their programs open until the waiver numbers have been exhausted.
- Basic adjudication patterns by the departments of health. Some states adjudicate waivers on a rolling basis while others accumulate all waiver applications and make a single adjudication, while yet other states hold off on decisions for medical specialists until the needs of primary care applicants have been fully satisfied.
- Differing attitudes toward physicians who are out of status. While some states refuse to adjudicate waiver applications for such physicians, other states do not consider the physician’s status as relevant to the goals of the waiver program.
- Reporting requirements. Many states are now requiring the facility to report and track how many Medicaid, Medicare, and uninsured patients are treated. An increasing number of states require some form of semi-annual reporting to verify the IMG is in fact acting to increase the accessibility of primary care in a HPSA or MUA.
- Language requirements. Some states have a language preference or requirement and place a preference for IMGs who speak a language used by a significant patient population of the facility or community, such as Spanish, Portuguese, Creole, or Vietnamese.

For a thumbnail outline of the waiver programs of the participating states, see the Appendix to this article.

**Delta Regional Authority**

The Delta Regional Authority (DRA) is a new program aimed at supporting primary care placements in an eight-state area, comprising a total of 240 counties and parishes in Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee. It is noted that participation may expand to even more counties and parishes in the future.

The DRA waiver program is structured to actively invite state participation. Procedurally, three copies of the completed DRA application must be simultaneously submitted to the DRA, one of which is then forwarded to the state health department. The state health agency then has a period of 45 days in which to voice concurrence with, or objection to, the waiver request. If the state does not notify DRA of an opinion, the DRA will advise the state that it is proceeding with waiver review. The DRA aims for a maximum review period of 60 days, demonstrating a commitment to prompt action, with or without state participation.

To meet the baseline criteria for a DRA waiver, the following key conditions of the DRA’s waiver program must be met:

- The physician must agree to provide primary care medical care as defined in the DRA guidelines, for not less than 40 hours per week in a site within a medically underserved area located in a county or parish within the DRA, for a period of not less than three years.
- The sponsor must demonstrate a good faith effort to recruit a U.S. doctor in the same salary range during the six months preceding the submission of the waiver application. Proof of recruitment will include, but shall not be limited to, advertisement in newspapers, medical journals, Internet sources, and notices to appropriate medical schools including all medical schools within the State.
- There may not be a non-compete clause in the contract.
- The physician must be in possession of a license to practice medicine in the State, or must be eligible for licensure.

48 Information regarding the Delta Regional Authority is available at [http://www.dra.gov](http://www.dra.gov).
The sponsoring facility must demonstrate that it provides medical care to Medicaid or Medicare eligible patients and the indigent uninsured.

If the employment contract provides for a minimum of five or more years of service, the DRA will support a request for a national interest waiver.

Like the ARC program, employment contracts include a liquidated damages clause.

As an interesting side note, Congress is also currently involved in authorizing and/or funding three additional agencies, which may further expand waiver options for IMGs. These are the Northern Great Plains Regional Authority, the Southeast Crescent Authority, and the Southwest Regional Border Authority. The status of those agencies, and any plans for implementing J-1 waiver programs, is not known at this time.

PARADIGM #2: EMPLOYMENT DIRECTLY WITH A FEDERAL FACILITY: THE DEPARTMENT OF VETERANS AFFAIRS

The Department of Veterans Affairs (VA) operates an IGA waiver program that is significantly different from the other federal IGA programs in that this agency’s program does not operate on a community-based model but rather on direct employment within a U.S. government facility. Procedurally, a VA waiver request is initiated within an individual VA facility, which files a waiver request through the Veterans Integrated Service Network (VISN) to the waiver review office within the VA Central Office. The VA Central Office makes the final decision whether to recommend a waiver, and its determination generally takes two to four months.

The VA waiver program is unique in that it enjoys statutory and regulatory exemptions from many of the general IGA requirements for IMGs. By its nature, the VA provides medical care to a special population with unusually high and special medical needs (e.g., geriatric and/or indigent patients). Because its patient population of veterans is dependent upon the VA system for medical care, the VA has historically acted as an IGA for specialists as well as primary care physicians. As a government entity that also conducts medical research, the VA has also acted as an IGA for physicians who conduct research provided it is a supplementary and subordinate activity to clinical care.

Although exempted from the recruitment requirement by federal regulations, the VA has a longstanding policy requiring the requesting VA facility to document extensive and unsuccessful recruitment efforts for U.S. physicians and a description of each potential candidate’s lack of qualifications or interest. VA written policy requires that the VA facility must directly employ the IMG on at least a 50 percent basis, thereby prohibiting the VA from serving as an IGA primarily for the benefit of an affiliated university. (Many VA facilities are affiliated teaching hospitals to university medical schools.) However, as IMGs are required to have full-time employment at a health care facility determined to be in the public interest, the prevailing view is that at least 40 hours per week must be spent directly working for the VA facility.

The 1996 changes to the INA stipulated that all IGA waiver recommendations were to be limited solely to facilities located in HPSAs or MUAs. This resulted in the unintended restriction upon the VA’s ability to act as an IGA if the individual facility is not located in a HPSA or MUA. Special legislation was passed in October 1997 to correct this and exempted VA facilities from the requirement that the IMG must practice in a HPSA or MUA. Additionally, VA facilities are exempted from the primary care restriction and may sponsor IMGs to work in medical specialties.

While the law grants the VA considerable latitude in pursuing waiver requests for IMGs, the VA system has exhibited some growing ambivalences toward its waiver program. As a general observation, the widespread perception within the physician workforce is that the VA system is characterized by unacceptable wage and working conditions which makes physician staffing particularly problematic. In contrast, IMGs oftentimes find the VA a very desirable employer if for no reason other than the opportunity to gain a waiver while practicing specialty

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49 The VA exemptions are stated at INA §214(l) and at 22 CFR §41.63(c)(4).

50 The Veterans Administration J-1 Waiver Request Policy Appendix is available at www.visalaw.com/IMG/va.pdf.

51 IIRAIRA §622 amended what then was INA §214(k), and now is INA §214(l) after the correction cited in note 52 below.

52 This oversight was corrected in the FY1998 VA appropriations bill on October 27, 1997 to create the current language in INA §214(l) and 22 CFR §41.63(c)(4).
medicine in an academic environment. This would seem to suggest the desirability for the Department of Veterans Affairs to actively support—if not embrace—its J-1 waiver program. Yet, despite the reliance by the individual VA facilities on IMGs, the VA Central Office has been requiring greater recruitment efforts and has instituted longer, more rigorous processing procedures in an apparent attempt to encourage the individual VA facilities to recruit U.S. physicians.

The IMG must hold at least a 50-percent appointment directly with the VA facility sponsoring the waiver, although IMGs holding full-time appointments are far more likely to obtain an IGA recommendation. The VA facility must document a sustained recruitment campaign to establish conclusively the unavailability of fully qualified U.S. physicians. The VA Recruitment Placement Service should be used over a period of time and advertisements must be placed in nationally circulated medical journals. Advertisements should not be older than one year, but the VA has proposed changes to the policy that would require advertisements to be no older than six months. Potential candidates must be interviewed no later than three months after they respond, and a detailed explanation must be submitted regarding the lack of qualifications of U.S. physician applicants.

Primary care physicians are preferred, but specialists are still being considered if the requesting VA facility provides a clear explanation of the unique need for the specialist IMG. Researcher IMGs are no longer eligible for waivers through the VA system unless the physician’s research endeavors are clearly subordinate to the physician’s clinical care services.

The VA now requires a three-year commitment from the IMG and has taken the position that any premature departure, regardless of circumstance, would render the waiver null and void. This policy differs sharply from general provisions in the INA and regulations that enable IMGs to change employers upon a showing of extenuating circumstances and relocation to another medically underserved area for the remainder of the three-year commitment.53

The VA also has taken the controversial position recently regarding how the agency will deal with the H-1B cap that applies to physicians in federal waiver positions. Specifically, the agency is not claiming an exemption from the cap for physicians at its university-affiliated facilities even though there are strong legal arguments supporting such a claim. The agency has instead suggested that its local facilities look at using the physician national interest waiver program to secure Employment Authorization Documents for physicians affected by the annual cap.

Finally, the VA has been adhering to a very controversial policy of barring IMGs in O-1 nonimmigrant visa status from VA waiver eligibility, unless they have first worked for, at minimum, two years within the VA system.54 As stated above, the home country requirement prohibits IMGs from obtaining H-1B, L-1, or permanent resident status, but does not prohibit an alien from obtaining an O-1 visa. The underlying rationale for the VA’s policy appears to be that the O-1 visa holder already possesses employment authorization and the waiver would be a redundant benefit. This rationale is arguably shortsighted because the O-1 is a temporary visa and does not enable the IMG to work on a permanent basis within the VA system, and under current VA guidelines, a VA waiver job offer must be for a permanent position. As a result of this policy, many world class IMGs are now declining practice opportunities within the VA system to the detriment of veteran health care objectives.

PARADIGM #3: MEDICAL RESEARCH OF NATIONAL SIGNIFICANCE: DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Department of Health and Human Services provides a unique IGA waiver program for IMGs engaged in pioneering research of national significance. The HHS waiver program is exempted from general requirements of IGA waivers for IMGs to provide patient care in designated HPSAs or MUAs.55

The HHS waiver program is unique in that HHS has promulgated its own formal regulations for the waiver program.56 Procedurally, an HHS waiver ap-

53 INA §212(l)(C)(ii).


55 INA §214(l)(1)(D) states that the three-year service in a HPSA requirement does not apply to IGA requests “to employ the alien full-time in medical research or training.” Regulations at 22 CFR §41.63(c)(4) limit requirements for federal IGAs to IMGs “willing to provide primary care in a designated” HPSA/MUA.

APPLICATION initially is submitted to the Executive Secretary of the HHS Exchange Visitor Review Board for an initial determination regarding the completeness of the application. After this initial review, the application is forwarded to the National Institutes of Health (NIH) for a “technical review,” focusing on the intrinsic scientific merits of the research and its relevance to expressed areas of national interest. The final decision is made by the HHS Exchange Visitor Waiver Review Board, which has the responsibility of weighing the benefits of the IMG’s contributions to research of national significance to the overall purpose of the J-1 exchange visitor program.

For HHS waiver purposes, the following core requirements must be met:

- The IMG must establish that he or she is an outstanding academic physician with a strong commitment to research, particularly bench research (i.e., laboratory based research), as opposed to clinical investigation and that the focus of such research will be in an area of high national priority;

- The petitioning academic medical center must show that it has attained a high level of research excellence, especially in areas of high national priority, and should be able to demonstrate ongoing funded research projects from federal or private philanthropic organizations and must show its commitment to creating and supporting a nurturing environment for the IMG’s research; and

- The petitioning academic medical center must prove that it has completed a fully competitive recruitment that did not result in finding a fully qualified U.S. applicant.

The HHS waiver program for IGAs can be challenging, but it has been a relatively consistent and stable source for waivers for stellar physicians engaged in important medical research. To a degree unparalleled in any other area of waiver practice, the development of a successful HHS waiver requires a great deal of coordination and communication among the alien physician-scientist, the employing institution, the academic department, and immigration counsel, as well as a full consideration of the scientific and public policy merits of the physician’s research work.57

CHANGE OF EMPLOYMENT AFTER OBTAINING IGA WAIVERS

Prior to 1994, retaining an IGA-recommended waiver was not an issue. Once granted, the waiver was final and irrevocable absent a showing that the waiver was obtained by fraud or bad faith. With the congressional authorization of the Conrad State 20 program, a new condition was imposed on all IGMS who received waivers under this program, which required a waiver beneficiary to work in H-1B status with the petitioning medical facility for a minimum of three years before gaining eligibility for permanent residence.59 Failure to comply with the three-year H-1B requirement would result in reinstatement of the home country requirement.60

The 1996 law provides a limited exception to the harsh consequences of a physician’s departure of the employing facility within the three-year period of required H-1B service. The law allows for the possibility of retaining the waiver upon the fulfillment of two conditions: (1) the existence of “extenuating circumstances” (as opposed to the physician’s own personal desire to change employer) which makes the physician’s continued employment palpably unfair; and (2) the physician’s relocation to a medically underserved area for the balance of the three-year H-1B service obligation.61 The law contains only two stipulated examples of extenuating circumstances: closure of the facility and hardship to the IMG. This is not an exhaustive list. In such circumstances, USCIS has the discretion to authorize the change of employer as long as the IMG can demonstrate a new job offer of full-time employment in the same or another HPSA or MUA/MUP for the remaining balance of the three-year term.

Neither the INA nor the USCIS regulations indicate the specific procedure to request an extenuating circumstances exemption for IGMS who received an H-1B after obtaining an IGA waiver. The law simply indicates that the Attorney General must be notified and has the authority to consider the extenuating circumstances. Also, the regulations concerning material changes in H-1B employment apply so as to

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58 Former INA §214(k), now INA §214(l).

59 INA §214(l), former INA §214(k). In addition, this section clarified that the prohibition appearing at INA §248(2) does not apply to IMG beneficiaries of IGA waivers.

60 Id.

require the filing of a new H-1B petition when there has been a change in employer and/or job location. Presumably, approval of an H-1B petition containing the extenuating circumstance exemption request would protect an IMG from being barred to eligibility for permanent residence for not completing the three-year commitment with the original petitioning medical facility. As discussed below, there is no requirement to notify the recommending IGA of a change in employment, although it may be a good practice pointer to make full disclosure to the agency so as to head off any recommendation to rescind the waiver from the IGA.

Current USCIS regulations provide that extenuating circumstances requests will be reviewed based upon the specific facts of a case. Because there is little regulatory guidance, it is not clear what constitutes “extenuating.” The IMG must provide an employment contract with a new medical facility for the balance of the three-year commitment along with documentation that the facility is located in a HPSA or MUA/MUP. In the case of an exemption request based on facility closure, evidence of past closure or anticipated closure must be provided. In the case of a claim of hardship, the IMG must establish that the hardship was caused by unforeseen circumstances beyond his or her control. The standard for hardship is not clearly defined under either the statute or the regulations. Interestingly, the IMG is not required to demonstrate “extreme,” “exceptional,” or even “extremely unusual” hardship. All that has to be demonstrated is hardship to the IMG.

Neither the INA nor the regulations provide clear guidance on how extenuating circumstances requests should be judged. Reports from immigration practitioners indicate that USCIS has tended to view favorably a new H-1B petition accompanied by reasonable evidence of the extenuating circumstances which has resulted in the IMG’s proposed departure. A letter from the former employer describing the circumstances leading to the termination or departure is usually a critical piece of evidence. Former employers oftentimes tend to be helpful in providing such letters, particularly if it is a mutually desired departure or if the employer may have breached the contract so as to become liable not only for the H-1B return transportation provisions, but also for back wage payment and other penalties. A statement from the IMG also may be necessary to describe the circumstances leading to the failure to fulfill the employment agreement with the original petitioning medical facility, depending on the quality and sufficiency of other evidence.

The timing of the filing of the new H-1B petition with an extenuating circumstances request is also critical. Technically, there is no H-1B grace period once an IMG is terminated from employment. Rather, an IMG who is terminated from H-1B employment falls out of nonimmigrant status immediately upon the date of termination. However, USCIS regulations governing the late filing of applications to extend the stay due to extraordinary circumstances “beyond the control of the applicant” may provide discretionary authority for USCIS to grant approval of a late filing of an H-1B petition accompanied by the extenuating circumstances request and supporting evidence. Where it is clear that termination of employment was unforeseen by and beyond the control of the IMG such as in a layoff, approval of a late filing of the H-1B petition with extension of stay request should not be a problem.

Notably, there is no requirement to obtain the prior consent or even concurrence from DOS or the IGA prior to changing employers. Nevertheless, most practitioners believe it is good practice to notify the IGA that recommended the waiver. This is a prudent practice particularly if the IMG received an ARC waiver or a Conrad State 30 waiver in a state that implements site visits to monitor compliance, or in states which stipulate that premature departure will result in a retraction of the waiver. Additionally, obtaining a letter of no-objection from the IGA will further support the favorable adjudication of the extenuating circumstances request by USCIS in the context of the H-1B petition for new employment.

Please note that IMGs who have left their original employer on bad terms may find themselves in contractual litigation with former employers over liquidated damages clauses such as those required by ARC, even if state or federal agencies have acquiesced to the change of employer.

If the state IGA is not notified and discovers that the IMG is no longer practicing at the original petitioning medical facility, it may report the incident to USCIS as a violation justifying revocation of the waiver and the institution of removal proceedings, although the effectiveness of such an action is unclear.

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62 INA §214(l).
63 INA §214(c)(5)(A).
IGA WAIVER COMPLIANCE AND ADDITIONAL EMPLOYMENT

One of the recurrent open issues is the extent to which a waiver beneficiary who has fulfilled his or her full-time period of employment in a qualifying facility can work in positions not qualifying for waiver benefits. This issue arises in two contexts: (1) a physician’s practice in facilities located in non-qualifying areas—i.e., geographic areas which are not medically underserved; and (2) the practice of specialty care medicine in instances in which the waiver is conditioned on primary care practice. Again, this issue arises solely in the context of employment over and above the required full-time commitment in the qualifying waiver position.

To-date, this issue has not been fully clarified, although various government officials have indicated that such employment if otherwise authorized, would not constitute a violation of the waiver.

In addition, there are instances in which a physician needs to commit a patient to a hospital which is not located in a designated medically underserved area, and to then provide follow-up medical treatment services. In such instances, the failure of a physician to continue to treat patients undergoing hospitalization would violate appropriate professional norms and would probably constitute malpractice. Yet, the issue remains open as to the degree this follow-up practice is allowed and whether periods spent providing hospital-based care should count toward fulfillment of the full-time employment requirement in the designated medically underserved area.

CONCLUSION

The review of the various IGA waiver programs indicates that this area of immigration law remains quite challenging and complex. The demand for physicians in general, and particularly those working in medically underserved areas, will quite likely continue to grow. Therefore, the J-1 waiver program becomes an indispensable physician recruitment tool.

By their nature, waiver cases involve coordination among the medical facility, the alien physician, the IGA, and immigration counsel. They oftentimes take place against harsh, compacted time frames. The policies of the various state IGAs vary widely, and even in those states maintaining detailed policies, there oftentimes arise unforeseen circumstances which influence waiver outcomes considerably. In addition, all too often, waiver cases are hampered by the uncertain state of the law itself, and the recurrent propensity of federal and state agencies to govern by policy memoranda, opinion letters, liaison reports, and even unwritten policy changes.

In light of the current uncertain state of immigration law, IMGs and their attorneys should carefully measure advice, weighing what is known against what is unknown. Full disclosure of the risks of any course of action is essential for the IMG and the employing medical facility to make informed decisions. Those IMGs who pursue IGA waivers, particularly IGA community-based waivers, must understand the enormous amount of work and commitment involved, including three full years in H-1B status, and the possibility of working in the underserved area for several more years while pursuing permanent resident status.
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<th>Site Pre-App Required</th>
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<tr>
<td>ALABAMA</td>
<td>HPSA for primary care; HPSA/ MUA for specialists</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn, and Psych. Includes ER placements of PCPs</td>
<td>Accepts up to 15 subspec per year if slots not needed for primary care</td>
<td>3 yrs to begin w/in 90 days.</td>
<td>No non-compete clause. Incl $250K damages for breach of contract provided</td>
<td>Defer to USCIS</td>
<td>AL license or proof of application</td>
<td>Oct 1 to Sept 30</td>
<td>Letter of intent may result in tentative site approval. Does not serve as placeholder</td>
<td>ARC and HHS options must be used first where applicable. Physicians must be BC/BE</td>
</tr>
<tr>
<td>Contact: Charles Lail  Tel: (334) 206-6396  Email: <a href="mailto:clai@adph.state.al.us">clai@adph.state.al.us</a>  Web: <a href="http://www.alapubhealth.org/opcrh/">www.alapubhealth.org/opcrh/</a></td>
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<td>ALASKA</td>
<td>HPSA only</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Geriatrics. Psych for MHPSA</td>
<td>Specialists participate in Conrad 30.</td>
<td>3 yrs to begin w/in 90 days. Offer must be signed by head of sponsor facility.</td>
<td>No specific parameters</td>
<td>Defer to USCIS</td>
<td>AK license or copy of application must be provided to show license has been sought</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
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<tr>
<td>Contact: Jean Findley Tel: 907/466-3091  Email: <a href="mailto:jean_findley@health.state.ak.us">jean_findley@health.state.ak.us</a>  Web:</td>
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<td>ARIZONA</td>
<td>HPSA, MUA, MUP or Mental Health HPSA</td>
<td>family or general practice, peds, ob/gyn, and general internal med</td>
<td>supports waivers for physicians in specialties where exceptional need is shown</td>
<td>3 yrs to begin w/in 90 days. No non-compete.</td>
<td>6 mos of recruiting including proof of ads.</td>
<td>Defer to USCIS</td>
<td>AZ license or proof of application</td>
<td>Deadlines 1/15, 4/15 and 8/15</td>
<td>No</td>
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<td>Practice must use sliding fee scale. Must accept walkins. No sponsorship for chronic care or rehab facilities.</td>
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<td>Contact: Mariam Vega  Tel: 602/542-1219  Email: <a href="mailto:vegami@hs.state.az.us">vegami@hs.state.az.us</a>  Web: <a href="http://www.hs.state.az.us/hsd/visa_waiver.htm">http://www.hs.state.az.us/hsd/visa_waiver.htm</a></td>
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<tr>
<td>ARKANSAS</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych</td>
<td>Will place specs only if primary care need met within the geographic area</td>
<td>3 yrs to begin w/in 90 days. No non-compete/non-solicit clause</td>
<td>Show effort to recruit US doctor for the vacancy for at least 6 mos prior to appl</td>
<td>Defer to USCIS</td>
<td>Not Given</td>
<td>Two application periods, 15 slots each; Oct 1 to Dec 31 and Jan 1 to Mar 31</td>
<td>No</td>
<td>Use Delta Regional Authority program for primary care placements where applicable</td>
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<tr>
<td>CALIFORNIA</td>
<td>HPSA only</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych</td>
<td>Geriatric and Infectious Diseases only</td>
<td>3 yrs to begin w/in 90 days. No non-compete clause</td>
<td>Evidence of 6 mos recruiting. May require additional evidence for private practices</td>
<td>May not be out of status</td>
<td>FMG must possess CA license at time of appl</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Salary must meet Level II Prevailing Wage</td>
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<tr>
<td>COLORADO</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn, and Psych</td>
<td>Possible depending on local conditions</td>
<td>3 yrs to begin w/in 90 days. Must include retention plan</td>
<td>6 months recruitment including recruiting through National Health Service and national advertising</td>
<td>Defer to USCIS</td>
<td>Must hold CO license or submit letter from State confirming license eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Facility must use sliding fee scale; M/M/ indigent; Applications accepted only from facility</td>
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Contact: Mary Fuller  Tel: 501/661-2771  Email: mfuller@healthyarkansas.com  Web: www.healthyarkansas.com/
Contact: Gillian Higgo  Tel: 916/449-5756  Email: ghiggo1@dhs.ca.gov  Web: www.ruralhealth.ca.gov/ruraljob/jobsj1.htm
Contact: Kitty Stevens  Tel: 303/692-2582  Email: kitty.stevens@state.co.us  Web: www.cdphe.state.co.us/pp/primarycare/J1.html
<table>
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<tr>
<td>CONNECTICUT</td>
<td>HPSA, MUA</td>
<td>All fields</td>
<td>No restrictions</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Show good faith effort to recruit US doctor, no specific parameters</td>
<td>Defer to USCIS</td>
<td>Must have CT license</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
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<td>Contact: Steve Carragher Tel: 860/609-7590 Email: <a href="mailto:Stephen.carragher@po.state.ct.us">Stephen.carragher@po.state.ct.us</a> Web: <a href="http://www.dph.state.ct.us/Licensure/apps/j1info.pdf">www.dph.state.ct.us/Licensure/apps/j1info.pdf</a></td>
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<tr>
<td>DISTRICT OF COLUMBIA</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych</td>
<td>5 slots available per year for subspecs</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Evidence of 6 mos regional recruitment</td>
<td>Defer to USCIS</td>
<td>DC license or submit proof of application</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Practice must use sliding fee scale. Must treat M/M and indigent. Must affiliate with DC Health Care Alliance. Facility must have been in existence for at least 1 year. Changes to program regs expected during 2004.</td>
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<td>Contact: Corey Palmer Tel: 202/442-5875 Email: <a href="mailto:corey.palmer@dc.gov">corey.palmer@dc.gov</a> Web:</td>
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<td>DELAWARE</td>
<td>HPSA, MUA</td>
<td>Internal med, family med, peds, ob/gyn and psych</td>
<td>Specialists allowed with show of compelling need</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Proof of 6 mos effort to recruit US doctor through all available means</td>
<td>Defer to USCIS</td>
<td>DE license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>Yes</td>
<td>Sliding fee scale. Must treat M/M/indigent</td>
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<td>Contact: Mario Nelson Tel: 302/744-4555 Email: <a href="mailto:menelson@state.de.us">menelson@state.de.us</a> Web:</td>
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<td>FLORIDA</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Ob/Gyn, Peds and Psych</td>
<td>PCPs may provide no more than 50% of services (20 hrs/w) in spec. No 100% subspec placements.</td>
<td>3 yrs to begin w/in 90 days</td>
<td>None needed</td>
<td>Defer to USCIS</td>
<td>Must have FL license or submit proof of application</td>
<td>Oct 1 to Sept 30</td>
<td>Yes</td>
<td>Physician must be BC/BE in a primary care spec. Priority given to public and non-profit facilities. Must employ sliding fee scale. At least 20% of patients must be M/M/ indigent</td>
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<tr>
<td>GEORGIA</td>
<td>HPSA only</td>
<td>Internal med, family med, Peds, Ob/Gyn and Psych</td>
<td>Not Given</td>
<td>3 yrs to begin w/in 90 days</td>
<td>No non-compete.</td>
<td>Must incl $250K for damages</td>
<td>minimum 6 mos of recruitment incl 1 print ad listing site and specialty</td>
<td>Defer to USCIS</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
</tr>
<tr>
<td>GUAM</td>
<td>HPSA, MUA</td>
<td>All areas</td>
<td>Specialist placements allowed</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Not given</td>
<td>Defer to USCIS</td>
<td>Not given</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Must treat M/M/ indigent.</td>
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<tr>
<td>HAWAII</td>
<td>HPSA, MUA</td>
<td>Internal med, family med, peds, ob/gyn</td>
<td>Not Given</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Not given</td>
<td>Defer to USCIS</td>
<td>Must have HI license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
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Karen Lundberg Tel: 850/245-4446 # 2704 Email: karen_lundberg@doh.state.fl.us Web: www.doh.state.fl.us/recruit/Communitydevelop.html

Contact: Lauren Gutierrez Tel: 229/401-3090 Email: lgutierrez@doh.state.ga.us Web:

Contact: Cindy Naval Tel: 671/736-7307 Email: clnaval@dphss.govguam.net Web:

Contact: Valerie Yin Tel: 808/586-4188 Email: sorh@mail.health.state.hi.us Web: www.hawaii.gov/doh/rural-health/j1visa.htm
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<th>Appl Period</th>
<th>Site Pre-Appl Required</th>
<th>Miscellaneous</th>
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<tr>
<td>IDAHO</td>
<td>HPSA, MUA or MUP</td>
<td>Family med., Internal med., Peds, Ob/ Gyn and Psych, BE/ BC req’d. PCPs may have subspec training</td>
<td>Not given</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Regional and nati print ads stating site location plus at least 6 cert ltrs to area med schs</td>
<td>Defer to USCIS</td>
<td>Must have ID license</td>
<td>Not given</td>
<td>No</td>
<td>Facility must use sliding fee scale, must serve M/M indigent and underserved pop. $1000 non-ref appl fee. Must use HHS as first option for PCPs</td>
</tr>
<tr>
<td>ILLINOIS</td>
<td>HPSA only</td>
<td>Internal Med, Family Med, Peds, Ob/ Gyn, Perm. Psych in Mental Health HPSA</td>
<td>Physicians may have subspecialty training if practice restricted to primary care. No spec placements</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Evidence of good faith recruiting No specific parameters given</td>
<td>Defer to USCIS</td>
<td>Must have IL license or submit proof of application submitted</td>
<td>Initial appl period Oct 1 to Oct 30. If slots still open, apps will be accepted Jan 1 to 30</td>
<td>No</td>
<td>Facility must be non-profit or public if located in urban area. If a population HPSA, at least 75% of patients must come from underserved population</td>
</tr>
<tr>
<td>INDIANA</td>
<td>HPSA, MUA</td>
<td>Internal med, Family med. Peds, Ob/ Gyn and Psych</td>
<td>Priority to PCPs. Spec permitted if compelling need</td>
<td>3 yrs to begin w/in 90 days</td>
<td>6 mos of recruitment w/print ad in medical journal</td>
<td>Defer to USCIS</td>
<td>IN license or proof of appl</td>
<td>Oct 1 to Oct 31. Priority to PCPs</td>
<td>No</td>
<td>Sliding fee scale, show high % of M/M/indigent.</td>
</tr>
</tbody>
</table>

Contact: Laura Rowen  Tel: 208/334-5993  Email: rowen@idhw.state.id.us  Web: (Draft Legislation) www3.state.id.us/oasis/S1291.html

Contact: Mary Ring  Tel: 217/782-1624  Email: mring@idph.state.il.us  Web: www.idph.state.il.us/pdf/1_application_fy2001.pdf

Contact: Nellie Simpson  Tel: 317/233-7679  Email: Web: www.in.gov/isdh/publications/llicwaivers.htm
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</thead>
<tbody>
<tr>
<td>IOWA</td>
<td>HPSA, MUA</td>
<td>Internal med, Family med, Peds. Ob/Gyn, General Surgery, Psych</td>
<td>Subspecialty placed with compelling show of need</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Show effort to recruit US doctor, no specific parameters</td>
<td>Defer to USCIS</td>
<td>IA license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>At least 10 slots allocated for specialist placements.</td>
</tr>
<tr>
<td>KANSAS</td>
<td>HPSA, MUA</td>
<td>Internal med, family med, Peds, Ob/Gyn, ER med and Psych</td>
<td>20% of slots reserved for specialists, evaluated by need</td>
<td>3 yrs to begin w/in 90 days</td>
<td>No non-compete</td>
<td>6 mos of recruitment to include listing w/KS recruitment center</td>
<td>KS license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Sliding scale, must treat M/M/indigent. Priority to PCP placements</td>
</tr>
<tr>
<td>KENTUCKY</td>
<td>HPSA, MUA</td>
<td>Internal med, family med, Peds, Ob/Gyn and Psych</td>
<td>Maximum of 20% of slots available for specialists depending on need</td>
<td>3 yrs to begin w/in 90 days</td>
<td>No non-compete</td>
<td>Minimum 3 mos of recruitment incl proof of notice sent to KY residency programs</td>
<td>Must possess KY license</td>
<td>Oct 1 to Oct 31</td>
<td>No</td>
<td>Sliding fee scale, must treat M/M/indigent. Priority to non-profits and FQHCs. Need must be at least 2000:1 for primary care placement</td>
</tr>
</tbody>
</table>

Contact: Carl Kulczyk Tel: 515/281-7223 Email: ckulczyk@idph.state.ia.us Web: [link]

Contact: Barbara Gibson Tel: 785/296-1200 Email: bgibson@kdhe.state.ks.us Web: [link]

Contact: John Hensley Tel: 502/564-8966 Email: john.hensley@mail.state.ky.us Web: [link]
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<tbody>
<tr>
<td>LOUISIANA</td>
<td>HPSA only</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych</td>
<td>Maximum 20% of slots available for subspec placement. Must establish dire need for specialist and show how spec will support primary care.</td>
<td>3 yrs to begin w/in 90 days. No non-compete clause</td>
<td>Minimum 6 mos recruiting, incl at least natl and regional print ads, proof of cert ltrs to area med schools, participate in Med Job Louisiana</td>
<td>Defer to USCIS</td>
<td>Possess LA license, or proof of application</td>
<td>Oct 1 to Sept 30</td>
<td>Yes</td>
<td>Site must obtain approval before making offer. Practice must employ sliding scale. Facility must treat M/M and indigent. Salary must meet Level II prevailing wage. Priority to placements where physician completed residency in LA. May use DRA and HHS where available for primary care placements.</td>
</tr>
<tr>
<td>MAINE</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych</td>
<td>Subspec placements allowed</td>
<td>3 yrs to begin w/in 90 days. Must incl retention plan</td>
<td>Evidence of 3 mos of good faith recruiting.</td>
<td>Defer to USCIS</td>
<td>Possess ME license or submit proof of application</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Practice must employ sliding fee scale. Must treat M/M and indigent. Private practices not favored</td>
</tr>
</tbody>
</table>

Paula Kramer Tel: 225/342-4702 Email: pkramer@dhh.state.la.us Web: www.dhh.state.la.us/offices/faq.asp?ID=88&FromSearch=1#Cat-34

Contact: Sophie Glidden Tel: 207/287-5524 Email: sophie.e.glidden@state.me.us Web: www.state.me.us/dhs/bohodr/orhpcpe.htm
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<tr>
<td>MARYLAND</td>
<td>HPSA only</td>
<td>Accept PCPS w/ residency training in family med., general pediatrics and psychiatry. Geriatric fellowship permitted.</td>
<td>Apps for sub-specs accepted from 6/1 to 9/30 for any open slots</td>
<td>3 yrs to begin w/in 90 days. No non-compete. Include Damages of $250K.</td>
<td>Minimum 6 mos recruitment through all available means</td>
<td>Defer to USCIS</td>
<td>MD license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Must treat M/M/ indigent. Salary must meet Prevailing Wage; preference to rural and community health centers</td>
</tr>
<tr>
<td>MASSACHUSETTS</td>
<td>HPSA only</td>
<td>Internal med, family med., pediatrics, obstetrics and psychiatry.</td>
<td>Allowed with proof of need</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Minimum 3 mos recruiting</td>
<td>Defer to USCIS</td>
<td>MA license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Must treat M/M/ indigent, sliding fee scale</td>
</tr>
<tr>
<td>MICHIGAN</td>
<td>HPSA only</td>
<td>Internal Med, Family Med., Peds, Ob/Gyn and psychiatry. willing to work at CMH facility, State prison or State Psych Hospital</td>
<td>Subspec placements allowed if slots available after primary care placements met. PCPs may possess subspecialty training</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Must provide evidence of good faith recruiting. No specific parameters</td>
<td>Defer to USCIS</td>
<td>Possess MI license or submit proof of application</td>
<td>Apps accepted in August only</td>
<td>Yes, $50 fee for appl</td>
<td>Placements ranked by need pursuant to HPSA score, and subject to lottery if there are competing applicants. $800 fee with each application (refunded if waiver not granted). $100 processing fee is non-refundable.</td>
</tr>
</tbody>
</table>

Contact: Antoinette Coward  Tel: 410/767-5695  Email: cowarda@dhmh.state.md.us  Web: www.fha.state.md.us/opcs/pco/html/mdj1visa waiverprog.html

Contact: Lisa Levine  Tel: 617/624-6060  Email: lisa.levine@state.ma.us  Web: www.state.ma.us/dph/fch/primcare.htm

Contact: Michele Lovaas  Tel: 517/347-3335  Email: mom@mimom.org  Web: www.mimom.org/page.cfm/41/
<table>
<thead>
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<tr>
<td>MINNESOTA</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn. Also Psych for MHPSA</td>
<td>Six slots for specialists based on compelling need. Priority to those also providing primary care</td>
<td>3 yrs to begin w/in 90 days. Include retention plan</td>
<td>evidence of sustained good faith recruiting, no specific parameters</td>
<td>Defer to USCIS</td>
<td>Must possess MN license or submit proof of application</td>
<td>Oct 1 to Sept 30. If slots open after July 1, will consider remaining specialist apps</td>
<td>No</td>
<td>Facility must treat M/M indigent. Facility must agree not to pursue LPR for two yrs</td>
</tr>
<tr>
<td>MISSISSIPPI</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn, Psych, Emergency Med only if compelling need</td>
<td>Specialists, as listed on website, are placed through the program</td>
<td>3 yrs w/pref to 4 yrs. Must start w/in 90 days. No non-compete clause</td>
<td>At least 6 mos of recruiting incl at least 1 natl ad w/practice site &amp; wage and proof of notices to area residency progs</td>
<td>Defer to USCIS</td>
<td>Must possess MS license or submit proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>Yes</td>
<td>Practice must employ sliding fee scale. must treat M/M and indigent. Physician must be BC or BE. Facility should place through ARC when possible. $250 fee required with final application.</td>
</tr>
<tr>
<td>MISSOURI</td>
<td>HPSA only</td>
<td>Internal med, family med, peds, ob/gyn, and Psych. ER if PCP role is shown</td>
<td>4 slots for specialists; prefer PCPs w/o spec training</td>
<td>3 yrs to begin w/in 90 days. Must incl $250K damages; must incl retention plan</td>
<td>6 mos effort to recruit US doctor</td>
<td>Defer to USCIS</td>
<td>MO license or proof of application</td>
<td>Oct 1 to Sept 30</td>
<td>Yes</td>
<td>Site pre-cert req’d Physicians must be BC/BE. $25 application fee. Must use sliding scale.</td>
</tr>
</tbody>
</table>

Contact: Lawrence Colaizy Tel: 651/282-3851 Email: lawrence.colaizy@health.state.mn.us Web: www.health.state.mn.us/divs/chs/orh_home.htm

Perelia Taylor Tel: 601/576-7216 Email: ptaylor@msdh.state.ms.us Web: www.msdh.state.ms.us/msdhsite/index.cfm?35,769,112,93.pdf

Contact: Ofc of Primary Care & Rural Health Tel: 800/891-7415 Web: www.dhss.state.mo.us/CommunityHealthInitiatives/RHPCj1visastate20.html
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<tr>
<td>MONTANA</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Psych, Ob/Gyn, and Geriatrics</td>
<td>Permitted on case by case basis where compelling need</td>
<td>3 yrs. to begin w/in 90 days. Include retention plan</td>
<td>Submit evidence of 6 mos good faith recruitment</td>
<td>Defer to USCIS</td>
<td>Must possess MT license, or submit proof of application</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Facility must employ sliding fee scale; M/M/indigent; offer competitive wage.</td>
</tr>
<tr>
<td>Contact: Jim Nybo  Tel: 406/444-3574  Email: <a href="mailto:jnybo@state.mt.us">jnybo@state.mt.us</a>  Web: <a href="http://www.dphhs.state.mt.us/hpsd/pubheal/healplan/primcare/j-info.htm">www.dphhs.state.mt.us/hpsd/pubheal/healplan/primcare/j-info.htm</a></td>
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<tr>
<td>NEBRASKA</td>
<td>HPSA, MUA</td>
<td>Internal med, family med, peds and ob/gyn</td>
<td>Permitted</td>
<td>3 yrs. to begin w/in 90 days</td>
<td>Good faith effort, no specific parameters</td>
<td>Defer to USCIS</td>
<td>NE license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Guidelines and application available if offer made by approved facility</td>
</tr>
<tr>
<td>Contact: Tom Rauner Tel: 402/471-0148  Email: <a href="mailto:Thomas.rauner@hhss.state.ne.us">Thomas.rauner@hhss.state.ne.us</a>  Web:</td>
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<tr>
<td>NEVADA</td>
<td>HPSA, MUA</td>
<td>Internal med, family med, peds, ob/gyn, geriatrics and psych. PCPs may have spec training.</td>
<td>Slots of sub spec on case-by-case Basis depending on need</td>
<td>3 yrs. to begin w/in 90 days. Must incl retention plan</td>
<td>Good faith effort, no specific parameters</td>
<td>Defer to USCIS</td>
<td>NV license or proof of approval from BME</td>
<td>Dec 1 to Jan 31</td>
<td>No</td>
<td>Facility must treat M/M indigent. Must participate in NV Medicaid and Check-up progs. Apps ranked by degree of shortage</td>
</tr>
<tr>
<td>Contact: Mark Hemmings  Tel: 775/684-4220  Email: <a href="mailto:mhemmings@nvdh.state.nv.us">mhemmings@nvdh.state.nv.us</a>  Web: health2k.state.nv.us/primary/jp-1.pdf</td>
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<tr>
<td>NEW HAMPSHIRE</td>
<td>HPSA, MUA</td>
<td>Internal med, family med, peds, ob/gyn and psych</td>
<td>Subspec placements possible, priority to PCPs</td>
<td>3 yrs. to begin w/in 90 days</td>
<td>No specific parameters</td>
<td>Defer to USCIS</td>
<td>NH license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Contact: Bryan Ayars  Tel: 603/271-4547  Email: <a href="mailto:bayars@dhhs.state.nh.us">bayars@dhhs.state.nh.us</a>  Web: <a href="http://www.dhhs.nh.gov/DHHS/BRHPC/default.htm">http://www.dhhs.nh.gov/DHHS/BRHPC/default.htm</a></td>
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<tr>
<td>NEW JERSEY</td>
<td>HPSA, possible expansion into MUA</td>
<td>Internal med, family med, ped, ob/gyn. PCPs should be BC/BE. Subspec training is not favorable</td>
<td>Very rare, but possible</td>
<td>4 yrs to begin w/in 90 days. No non-compete. Incl retention plan</td>
<td>12 mos of recruitment needed</td>
<td>Defer to USCIS</td>
<td>NJ license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Facility must be licensed and must treat M/M/ indigent. Must use sliding fee scale. Salary must meet prevailing wage.</td>
</tr>
<tr>
<td>NEW MEXICO</td>
<td>HPSA, MUA</td>
<td>Family med, internal med, ped and ob/gyn</td>
<td>specialists may be placed in HPSA, MUA or MUP with compelling need. Must be BC/BE</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Facility must recruit thru NM Health Resources or show at least 12 mos recruiting prior to appl</td>
<td>Defer to USCIS</td>
<td>Must possess NM license</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Facility must accept patients regardless of ability to pay. Must accept M/M and participate in NM Medicaid FQHCs and Certified Rural Health Clinics are eligible</td>
</tr>
<tr>
<td>NEW YORK</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med and Peds.</td>
<td>Specialist placements allowed with proof of need and based on availability</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Evidence of 6 mos of good faith recruitment</td>
<td>Defer to USCIS</td>
<td>Possess NY license or submit proof of eligibility</td>
<td>Oct 1 thru March 31. Decisions by June</td>
<td>No</td>
<td>Priority to HPSA. Facility should use ARC/HHS where possible. Priority to outpatient sites w/ family med, internal and peds. Facility must show services to high need/ special pops</td>
</tr>
</tbody>
</table>

Contact: Linda Anderson Tel: 609/292-1495 Email: Linda.anderson@doh.state.nj.us Web: http://www.state.nj.us/health/j-1/

Contact: Kim Kinsey Tel: 505/841-5871 Email: kimk@doh.state.nm.us Web: http://www.nmhr.org/nmj1.html

Contact: Gabriel Chavez Tel: 505-841-5866 Email: gabrielc@doh.state.nm.us

Contact: Steve Swanson Tel: 518/473-7019 Email: sas03@health.state.ny.us Web: www.health.state.ny.us/nysdoh/dpprd/01infbd.htm
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<tbody>
<tr>
<td>N. CAROLINA</td>
<td>HPSA only</td>
<td>Internal Med, Family Med, Peds, and Ob/Gyn</td>
<td>No slots available for specs. No subspec training permitted for PCPs.</td>
<td>4 yrs to begin w/in 90 days</td>
<td>Evidence of good faith recruiting, no specific parameters</td>
<td>Defer to USCIS</td>
<td>Must possess NC license</td>
<td>Year Round</td>
<td>No</td>
<td>Applications must come from employer or attorney</td>
</tr>
<tr>
<td>NORTH DAKOTA</td>
<td>HPSA, MUA</td>
<td>Preference for General Internal Med and Family Med</td>
<td>Specialist placements possible but rare</td>
<td>3 yrs to begin w/in 90 days. No non-compete clause</td>
<td>Evidence of 6 mos recruitment effort, w/ limited exceptions</td>
<td>Defer to USCIS</td>
<td>Possess ND license or submit proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Possible changes to program in 2004</td>
</tr>
<tr>
<td>OHIO</td>
<td>HPSA</td>
<td>Family med, internal med, peds, ob/gyn and psych</td>
<td>Subspec slots available only after 4/15</td>
<td>3 yrs to begin w/in 90 days. No non-compete.</td>
<td>Minimum 6 mos recruitment</td>
<td>Defer to USCIS</td>
<td>OH license or proof of application</td>
<td>Oct 1 to Sept 30; Specialists apply by 4/15</td>
<td>Yes</td>
<td>Must use sliding fee scale. Must treat M/V indigent. Must use ARC and HHS as first choice for placement where possible.</td>
</tr>
</tbody>
</table>

Contact: Tom Tucker Tel: 919/733-2040 Email: tomtucker@mindspring.com Web: 
Contact: Mary Amundson Tel: 701/777-4018 Email: mamundson@medicine.nodak.edu Web: www.med.und.nodak.edu/depts/rural/rhw/j1/ 
Contact: Phil Styer Tel: 614/644-8508 Email: BCHSSD@gw.odh.state.oh.us Web: www.odh.state.oh.us/odhprograms/visa/visa1.htm
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<th>Site Pre-App Required</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>OKLAHOMA</td>
<td>HPSA</td>
<td>Family med, internal med, peds, ob/gyn and psych. Physician must be BC/BE</td>
<td>Not permitted</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Not given</td>
<td>Defer to USCIS</td>
<td>OK license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>5 slots allocated for psychiatry</td>
</tr>
<tr>
<td>OREGON</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych</td>
<td>6 slots for subspec. may be reallocated to meet demand</td>
<td>3 yrs to begin w/in 90 days. No non-compete clause</td>
<td>Provide documentary evidence of 6 mos recruiting</td>
<td>Defer to USCIS</td>
<td>Possess OR lic or submit proof of application</td>
<td>Oct 1 to Sept 30</td>
<td>Yes for PCPs with subspec training</td>
<td>Public clinics given priority. Facility must use sliding fee scale, 20% of patient visits must be Medicaid/low-inc uninsured. $2000 appl fee req’d Approved LCA req’d to show that salary meets prevailing wage</td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych</td>
<td>Subspecs based on need.</td>
<td>3 yrs to begin w/in 90 days. No non-compete clause; incl $250K damages</td>
<td>Evidence of 6 mos recruiting incl natl ad &amp; intns to residency programs</td>
<td>Physician must be in lawful status</td>
<td>Possess PA lic or submit proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>Contact Bureau of Health Planning to give basic info before appl material can be obtained</td>
<td>Facility must contact Bureau for site approval before finalizing offer. Preference to physicians in last 6 months of residency</td>
</tr>
</tbody>
</table>

Contact: Carrie Thompson Tel: 405/271-8427 Email: carrie@health.state.ok.us Web:  
Contact: Dia Shuhart Tel: 503/945-9467 Email: dia.shuhart@state.or.us Web: www.dhs.state.or.us/publichealth/hsp/conrad/index.cfm  
Contact: Connie Hanna Tel: 717/772-6298 Email: channa@state.pa.us Web: www.dsf.health.state.pa.us/health/cwp/browse.asp?A=169
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<tr>
<td>RHODE ISLAND</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn, and Psych</td>
<td>Only spec placements child psych, anesthesies &amp; pain mgmt in HPSA/MUA</td>
<td>3 yrs to begin w/in 90 days. Include retention plan. No non-comp clause</td>
<td>Evidence of good faith recruiting, no specific parameters.</td>
<td>Defer to USCIS</td>
<td>Possess RI license or submit proof of eligibility</td>
<td>Oct 1 to Sept 30. Accepts begin June 15.</td>
<td>No</td>
<td>Priority to Spanish-speaking PCPs including Psych and OB, also anesthesies. Incl placements for clinical/teaching appts to Brown Univ</td>
</tr>
<tr>
<td>S. CAROLINA</td>
<td>HPSA, MUA</td>
<td>Family med, internal med, peds, ob/gyn and psych</td>
<td>Permitted</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Proof of recruiting, no specific parameters</td>
<td>Defer to USCIS</td>
<td>SC license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Must use sliding fee scale, must treat M/M/ indigent</td>
</tr>
<tr>
<td>SOUTH DAKOTA</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych</td>
<td>Specialist placements allowed</td>
<td>3 yrs to begin w/in 90 days. No non-compete clause. Include retention plan</td>
<td>Evidence of 6 or more months of recruiting</td>
<td>Defer to USCIS</td>
<td>Must possess SD license or submit proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Facility must employ sliding fee scale. $200 nonrefundable processing fee</td>
</tr>
</tbody>
</table>

Contact: Bruce McIntyre  Tel: 401/222-3855  Email: brucem@doh.state.ri.us  Web: www.healthri.org/hsr/professions/visa/j1visa.htm
Contact: Mark Jordan  Tel: 803/898-0766  Email: jordanma@columb61.dhec.state.sc.us  Web: 
Contact: Halley Lee  Tel: 605-773-6320  Email: halley.lee@state.sd.us  Web: www.state.sd.us/doh/rural/jfwaiver.htm
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<tr>
<td>TENNESSEE</td>
<td>HPSA, MUA and HRSA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych. PCPs must have completed subspec training in specific approved fields</td>
<td>See regs. Permitted in specific spec fields.</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Evidence of 6 mos of recruitment</td>
<td>Defer to USCIS</td>
<td>Must possess TN license or submit proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Facility must be enrolled with TennCare program</td>
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<tr>
<td>TEXAS</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych.</td>
<td>Specialists allowed with compelling need</td>
<td>3 yrs to begin w/in 90 days</td>
<td>No specific guidelines</td>
<td>Defer to USCIS</td>
<td>Possess TX license or submit proof of eligibility</td>
<td>Oct 1 to Aug 31</td>
<td>No</td>
<td>Salary must meet prevailing wage. $2000 fee with application; see rules for refund policy</td>
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<tr>
<td>UTAH</td>
<td>HPSA, MUA and MUP only</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych</td>
<td>Available if site is within HPSA/MUA/MUP and can document compelling need.</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Minimum of 1 yr recruitment</td>
<td>Defer to USCIS</td>
<td>Must possess UT license, or submit proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Facility must employ sliding scale, treat M/M/indigent</td>
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<tr>
<td>VERMONT</td>
<td>HPSA, MUA</td>
<td>Internal med, family med, peds, ob/gyn and Psych</td>
<td>Evaluated on case-by-case basis</td>
<td>4 yrs to begin w/in 90 days</td>
<td>Proof of recruiting, no specific parameters</td>
<td>Defer to USCIS</td>
<td>VT license or proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Facility must consult VDH before offer is made</td>
</tr>
</tbody>
</table>

Contact: Ann Phillips  Tel: 615/741-2101  Email: ann.phillips@state.tn.us  Web: www2.state.tn.us/health/rural/j1visa0.html

Contact: Connie Berry  Tel: 512/458-7518  Email: connie.berry@tdh.state.tx.us  Web: www.tsh.state.tx.us/chprj1info.htm

Contact: Erin Olsen  Tel: 801/538-8214  Email: el Olsen@utah.gov  Web: www.health.state.ut.us/primary_care/employment.html

Contact: Craig Stevens  Tel: 802/863-7513  Email: cstevens@vdh.state.vt.us  Web: www.vdh.state.vt.us
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<td>VIRGINIA</td>
<td>HPSA, MUA, MUP</td>
<td>Internal med, family med, Peds, ob/gyn, and psych</td>
<td>Subspec placements possible with show of need</td>
<td>3 yrs to begin w/in 90 days. No non-compete clause.</td>
<td>Proof of 6 months recruiting</td>
<td>Defer to USCIS</td>
<td>VA license needed</td>
<td>Oct 1 to Sept 30</td>
<td>Yes</td>
<td>Must treat M/M/indigent, must use sliding fee scale. Priority to HPSA sites.</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>HPSA or whole-county MUA</td>
<td>Internal med, family med, Peds, ob/gyn and psych</td>
<td>25% of slots available to specialists</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Proof of 6 months recruiting</td>
<td>Defer to USCIS</td>
<td>WA license or proof of application</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Must treat M/M/indigent, using sliding fee scale. If PCP slots unused after 6/1, additional spec placements permitted</td>
</tr>
<tr>
<td>WEST VIRGINIA</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Ob/Gyn and Psych</td>
<td>Subspecs allowed on case-by-case basis with proof of need</td>
<td>4 yrs to begin w/in 90 days. No non-compete clause</td>
<td>Provide evidence of 6 mos recruiting</td>
<td>Defer to USCIS</td>
<td>WV license or submit proof of eligibility</td>
<td>Oct 1 to Sept 30</td>
<td>Yes, site pre-cert req'd</td>
<td>Practice must employ sliding fee scale. Facility must treat M/M/indigent</td>
</tr>
<tr>
<td>WISCONSIN</td>
<td>HPSA, MUA</td>
<td>Internal Med, Family Med, Peds, Psych and Ob/Gyn</td>
<td>No subspec placements</td>
<td>3 yrs to begin w/in 90 days</td>
<td>Must provide documentary evidence of good faith recruitment, no specific parameters</td>
<td>Defer to USCIS</td>
<td>Must possess WI license, or submit proof of application</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td>Practice must employ sliding fee scale; M/M/indigent</td>
</tr>
</tbody>
</table>

Contact: Karen Reed  Tel: 804/864-7427  Email: Karen.Reed@vdh.virginia.gov  Web: www.vdh.virginia.gov/primcare/center/j1/info.asp

Contact: Jennell Prentice  Tel: 360/238-2814  Email: jennell.prentice@doh.wa.gov  Web: www.doh.wa.gov/hsqa/ocr/hr&jrj1.htm

Contact: Devney Friel  Tel: 304/558-4382  Email: devneyfriel@wvdhr.org  Web: www.wvdhr.org/wvdojr/j1/j1%5Fwaiver%5Fpolicy.htm

Contact: Kathie Lenzen  Tel: 608/264-6528  Email: lenzeki@dhfs.state.wi.us  Web: dhfs.wisconsin.gov/dph_bcdhp/j_1visa/index.htm
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<tr>
<td>WYOMING</td>
<td>HPSA, MUA</td>
<td>Family med, internal med, peds, ob/gyn</td>
<td>Not given</td>
<td>3 yrs to begin w/in 90 days</td>
<td>No specific parameters</td>
<td>Defer to USCIS</td>
<td>Must have WY license or proof of application</td>
<td>Oct 1 to Sept 30</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Contact: Billee Jelouchan  Tel: 877/304-6138  Email: bjelou@whrn.org  Web:
DEVELOPING A PHYSICIAN RECRUITMENT BUDGET
Prepared by: Chris Kashnig

Introduction:

It is important for an in-house physician recruiter to develop and maintain an annual budget and cost out expenses per search. Certain searches will be more difficult and more expensive than others. The recruiter will assist the hospital Finance Department greatly by allocating expenses to a given department. This is particularly important if a hospital is “charging back” all or a portion of the recruitment expenses to a hospital department or a private group.

One will find that it costs roughly $25,000 to recruit a physician. However, there are exceptions. Hospitals with residency or fellowship programs who recruit their own residents or fellows will pay much less. In addition, there are economies of scale which can reduce the average cost. A husband/wife team will normally be less expensive than two separate searches. In addition, if a recruiter is recruiting multiple physicians within a given specialty (for example, three Pediatricians), average costs should be reduced slightly. A different sort of exception would be an extremely rare sub specialist. This cost will likely exceed the average.

A) When developing an in-house physician recruitment budget, one should have the following line items:
- Staff salaries and fringe benefits related to recruitment.
- Interview expenses—travel and related interview expenses for candidates.
- Out-of-pocket expenses—sourcing expenses to identify candidates.
- Relocation expenses—expenses to relocate new physicians to your area.
- Background checks—expenses to verify the background of new physicians.
- Miscellaneous expenses—might include expenses for outside agencies.

Note: Some of these expenses are variable and can be attributed directly to a given search. (Example: The relocation expense for a given physician.) Others are fixed expenses and have to be allocated over all searches. (Example: The recruiter’s salary and fringe benefits.)

B) In certain cases hospitals and clinics have decided to outsource the physician recruitment function to outside agencies. In this case a budget will include the following line items:
- Agency fees.
- Some staff salaries and fringe benefits.
- Interview expenses.
- Relocation expenses.
- Background checks.

Break-even Point: There is a point where it is equally expensive to recruit in-house vs. outsourcing the recruitment function. It is roughly seven searches. Remember, the variable costs can easily be allocated to a given search. The fixed costs have to be spread out equally over all of them. Below seven searches, the fixed costs (primarily salary and fringe benefits)
are so expensive that they increase the average to the point where it is more expensive than the cost would be if outsourced. This is why many small, rural hospitals do not have a full time in-house physician recruiter. They do not recruit enough physicians to require a full time person. Frequently, they have an individual who handles a variety of roles within the organization, for example, recruitment, marketing, and public relations.
REFERENCES

• Guide to Medical Specialties, February 2006; www.abms.org
  "Physician Characteristics and Distribution"
  "State Medical Licensure Requirements"
  “Graduate Medical Education Directory"

• Medical Malpractice Insurance
  http://www.camedicalmalpractice.net/purchasing.htm

• American Board of Medical Specialties
  www.abms.org