ARKANSAS J-1 VISA WAIVER PROGRAM

2024-2025 J-1 Visa Waiver Application Form

(Please type or print legibly)

Application Type: Conrad Designated____ Conrad Non-Designated____ Date: _____

IMG Physician:_____ Female:____ Male:____
Last Name First Name Middle Name

Place of Birth:_____ Date of Birth:_____
City Country Month / Day / Year

Nationality:_____ Visa Status:_____ DOS Waiver Review File No: _____

Employer Name:_____ Telephone:_____

Employer Address/City/Zip: _____

Employer Administrator/CEO:_____ E-mail: _____

Practice Site Name:_____ Telephone:_____

Practice Site Address/City/County/Zip: _____

_____

Additional Practice Site Addresses/Counties: _____

_____

_____

IMG's Medical Specialty:_____ Subspecialty: _____

MUA/MUP ID or HPSA ID for all designated practice sites or non-designated patient populations:

HPSA / MUA Name	HPSA /MUA ID#

Attorney or Representative:_____

Address: _____

Telephone:_____ E-mail:_____ Fax:_____

ARKANSAS J-1 VISA WAIVER PROGRAM

IMG Physician Affidavit and Agreement

I_____, being duly sworn, hereby request the Arkansas J -1 Visa Waiver Program to review my application for the purpose of requesting a waiver of the foreign residency requirement as set forth in my current visa, pursuant to the terms and conditions as follows:

I understand and acknowledge that the review of this request is discretionary and that in the event a decision is made not to grant my request, I hold harmless the State of Arkansas, the Arkansas Department of Health, Arkansas State Board of Health members, any and all State of Arkansas employees, agents and assigns from any action or lack of action made in connection with this request.

I further understand and acknowledge that the entire basis for the consideration of my request is the state of Arkansas' voluntary policy and desire to improve the availability of medical care in the federally designated medically underserved areas of the State.

I understand and agree that in consideration for a waiver which eventually may or may not be granted, I shall provide primary or specialty medical care to patients for a minimum of 40 hours per week, in not less than four days a week, within the area or areas stipulated in my employment contract only and which are designated by the Secretary of the United States Department of Health and Human Services as having a shortage of health care professionals, or if I accept a non- designated placement, to patients residing in a neighboring HPSA(s) or MUA/P(s) as indicated in my employment. I agree to begin employment at such facility within 90 days of receiving such waiver and agree continue to work for a total of not less than 3 years in accordance with paragraph (2), Section 214(l) of the Nationality and Immigration Act.

I agree to incorporate all the terms of this Affidavit and Agreement into any and all employment agreements I enter. I further agree that any employment agreement I enter shall not contain any provision which modifies or amends any of the terms of this Affidavit and Agreement.

I understand and agree that the medical services I will render are in a Medicare and Medicaid certified facility which has an open, non-discriminatory admissions policy and that will accept indigent, uninsured patients.

I expressly understand that this waiver of my foreign residence requirement must ultimately be approved by the United States Citizenship and Immigration Services, and I agree to provide written notification of the specific location and nature of my practice to the Arkansas J-1 Visa Waiver Program upon request.

I understand and acknowledge that if I willfully fail to comply with the terms of this Affidavit and Agreement, the Arkansas J-1 Visa Waiver Program will notify the United States Citizenship and Immigration Services of the United States Department of Homeland Security.

I hereby declare and certify, that I do not now have pending nor am I submitting during the pendency of this request, another request to any state Department of Public Health, or equivalent, other than the Arkansas Department of Health to act on my behalf in any matter relating to a waiver of my two-year home-country physical presence requirement.

I avow that I have never had any medical license suspended or revoked and that I am not subject to any criminal investigation or proceedings by any medical licensing authority.

I declare under the penalties of perjury that the forgoing is true and correct.

Signed_____

IMG Physician Date Type/Print Physician Name

Employer/Facility: _____

Address: _____

_____

Subscribed and sworn to before me

this_____day of_____, 20___

_____

Notary Public