

**ECFMG SPONSORED J-1 EXCHANGE
VISITOR VISA SPONSORSHIP REQUEST FORM**
(To be completed by medical resident/clinical fellow and GME program)

The Educational Commission for Foreign Medical Graduates (ECFMG) is the sole entity authorized by the U.S. Department of State to sponsor J-1 Exchange Visitor physicians enrolled in accredited or non-standard Graduate Medical Education (GME) training programs. The staff of the Office of International Services (OIS) facilitates this sponsorship by serving as the Training Program Liaisons (TPLs) between the UT Health Science Center at San Antonio's GME programs, sponsored medical residents and clinical fellows, and ECFMG.

GENERAL GUIDELINES

- This process is to be used for an international medical graduate (IMG) who requires ECFMG J-1 visa sponsorship under [GME Policies 2.14.a \(Medical Residents Visas\) and 2.14.b \(Clinical Fellow Visas\)](#) to engage in a medical residency or clinical fellowship program at the UT Health Science Center at San Antonio.
- In order to qualify for initial sponsorship, the IMG must be officially accepted to a residency or clinical fellowship program at the university.
- Continuation of sponsorship is based on the IMG demonstrating successful progress in his/her designated program and remaining in good standing. The IMG is expected to advance through progressive levels of training that are required by the specialty/subspecialty Boards.
- ECFMG J-1 Exchange Visitor physicians are only allowed to engage in activities that are a part of their formal GME training programs. Programs may contact the OIS if they have questions about allowable activities.

REQUIRED DOCUMENTS TO PROCESS J-1 REQUEST

- ECFMG Sponsored J-1 Exchange Visitor Visa Request Form

*Section A must be completed by the medical resident or clinical fellow requesting sponsorship.

*Section B must be completed by the sponsoring GME program.

- Please select the appropriate checklist below for the anticipated GME program and submit all documentation indicated on the checklist along with this form completed to the OIS. To determine which checklist to select, see the ECFMG Supporting Documentation Checklists [website](#).

[Initial ECFMG Sponsorship in ACGME-accredited Clinical Training](#)

[Continuation of ECFMG Sponsorship in ACGME-accredited Clinical Training](#)

[Initial ECFMG Sponsorship in Non-Standard Clinical Training](#)

[Continuation of ECFMG Sponsorship in Non-Standard Clinical Training](#)

[Initial of ECFMG Sponsorship in Research/Non-Clinical Program](#)

[Continuation of ECFMG Sponsorship in Research/Non-Clinical Program](#)

[Continuation of ECFMG Sponsorship to sit for ABMS Board Examination](#)

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PROCESS AND TIMEFRAME

The form should be completed by the sponsoring GME program and submitted with all required documentation indicated on the appropriate ECFMG checklist to the OIS. Within 5 to 10 business days of receipt of the packet, the OIS will review it and notify the GME program if any information and/or documents are missing. Once the OIS receives the complete information and/or documentation, within 1 to 3 business days the OIS will submit the request packet to ECFMG. ECFMG requires 4 to 8 weeks to review the applications and issue and send the DS-2019 form to the OIS.

For medical residents or clinical fellows entering the U.S. initially, they require the DS-2019 form to apply for an ECFMG J-1 visa at a U.S. consulate abroad to enter the U.S. **The OIS will mail the ECFMG J-1 DS-2019 form to the applicant for all initial sponsorship requests via eShip Global. Please provide the following information to bill the sponsoring program for the cost of mailing:**

Username: _____ Project ID (PID): _____ Dept. ID: _____

For continuing ECFMG J-1 medical residents or clinical fellows, they can pick up the new DS-2019 form in person at the OIS. Program coordinators cannot pick up the DS-2019 forms for them.

SECTION A: (TO BE COMPLETED BY MEDICAL RESIDENT OR CLINICAL FELLOW)

USMLE/ECFMG Number ____-____-____-____-____-____-____

Gender: Male Female

Marital Status: Single Married

Are you currently in the U.S.? Yes No

When did you enter the U.S.? (if applicable) ____/____/____ (mm/dd/yyyy)

What is your current visa status? (if applicable) _____ When does your current visa status expire? ____/____/____

If you are currently in the U.S., do you intend to apply to change status within the United States or leave the U.S. to apply for an ECFMG J-1 visa?

Have you ever previously been in the United States as a J-1 Exchange Visitor? Yes No

Will you be requesting sponsorship for dependents (spouse/child)? Yes No If so, how many? _____
(Applicants will be requested to insert information and upload documentation regarding accompanying dependents in the ECFMG Online Applicant Status and Information System (OASIS) once the OIS has submitted the ECFMG J-1 request to ECFMG.)

Applicant's Family Name Given Name Middle Name

Date of Birth (mm/dd/yyyy) City of Birth Country of Birth

Country of Citizenship Country of Last Legal Permanent Residence

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E-mail address _____ Phone number: _____

Permanent Foreign Address:

Number and Street

City State/Province Country

Postal Code

U.S. Permanent Address (if applicable):

Street Number and Name

City State/Province Country

Postal Code

Address to Send DS-2019 Form: (Postal boxes are not acceptable.)

Permanent Foreign Address, as listed above

Current U.S. Address, as listed above

Other Address Indicated Below:

Number and Street City

State/Province Country Postal Code

MANDATORY INSURANCE

The U.S. Department of State requires all Exchange Visitors in J-1 Exchange Visitor nonimmigrant status and their J-2 dependents to purchase comprehensive sickness and accident insurance for the entire J-1 Exchange Visitor program duration in the United States. ECFMG provides the required medical evacuation and repatriation of remains insurance (but not the required medical insurance) to ECFMG J-1 physicians and their J-2 dependents. It is the J-1 physicians' responsibility to ensure that their medical insurance plans meets the regulatory insurance requirements and that J-2 dependents also have the required insurance coverage. More information about the mandatory medical insurance requirements can be found on the [ECFMG website](#).

DECLARATION

By signing below I attest that all the information I provided above is true and correct and that I understand that as an ECFMG J-1 Exchange Visitor,

I will be responsible for maintaining my own legal immigration status;

I must ensure that my immigration documents do not expire;

If I allow the date on my DS-2019 Form to expire and I remain in the U.S., I will not be in lawful immigration status and may be subject to deportation by the U.S. Department of Homeland Security;

I must follow and comply with the sickness and accident insurance requirements and policies as described on the ECFMG website and my failure to do so may result in me having to immediately depart the U.S.;

I may only engage in activities that are an official part of my formal training program and I may not volunteer or moonlight (work outside of designated GME training program) in any capacity neither at the UT Health Science Center at San Antonio nor anywhere else;

I may not change from a clinical track to a research track without first notifying the OIS and receiving approval from ECFMG;

I must notify ECFMG via OASIS, the U.S. Citizenship and Immigration Services, and the OIS of any changes in my address, phone number, or email; and

I must notify the OIS of any proposed changes in my training plan (e.g. leave of absence, remedial training, resignation, and gaps in training) and receive advance approval from ECFMG before any such changes take effect.

Applicant's Signature: _____ Date: _____

SECTION B: (TO BE COMPLETED BY SPONSORING GME PROGRAM)

_____	_____	_____
ACGME Institution ID	ACGME or Non-Standard Program ID	PGY Level / (Categorical/Prelim)

Specialty/Sub-specialty		
_____	_____	
Start Date of Program	End date of Program	
_____	_____	_____
Total # Training Yrs. in U.S. of Applicant	UHS Hospital Stipend Amount	Other Funding Source & Amount (if applicable)
_____	_____	_____
Program Coordinator	Email Address	Phone Number

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For continued sponsorship, please confirm that the above-mentioned resident/fellow is / is not making normal progress in their designated clinical training program.

Is the resident/fellow on probation or in remediation? Yes No

Will the trainee be engaged in any form of research? Yes No

If yes, explain: _____

Please indicate **all** the **major** participating training sites in which the resident or clinical fellow will be **engaged in clinical training** for the program year:

- | | |
|---|---|
| <input type="checkbox"/> UT Health Science Center at San Antonio, 7703 Floyd Curl Dr. | <input type="checkbox"/> UHS Robert B. Green, 903 W. Martin St. |
| <input type="checkbox"/> CTRC, 7979 Wurzbach Rd. | <input type="checkbox"/> University Hospital, 4502 Medical Dr. |
| <input type="checkbox"/> Audie L. Murphy VA Hospital, 7400 Merton Minton Blvd. | <input type="checkbox"/> UT Medicine MARC, 8300 Floyd Curl Dr. |

Other [Please provide specific address(es). May attach additional page with list of sites.]:

At which one of the above training sites will the resident or clinical fellow be predominantly spending the majority of his/her time during the program year? _____

DECLARATION

By signing below we attest that all the information we provided above is true and correct and that we understand that as a GME program sponsoring an ECFMG J-1 Exchange Visitor:

The sponsored medical resident or clinical fellow may only engage in activities that are an official part of the formal training program and s/he may not volunteer or moonlight in any capacity neither at the UT Health Science Center at San Antonio nor anywhere else;

The sponsored medical resident or clinical fellow may not change from a clinical track to a research track without first notifying the OIS and receiving approval from ECFMG;

We must immediately notify the OIS of any proposed changes in the sponsored individual's training plan (e.g. leave of absence, remedial training, resignation, and gaps in training) and receive advance approval from ECFMG before any such changes take effect; and

We must timely notify the OIS if a sponsored medical resident or clinical fellow is not demonstrating successful progress in their designated program and/or does not remain in good standing.

Program Coordinator's Name: _____

Program Coordinator's Signature: _____

Date: _____

Program Director's Name: _____

Program Director's Signature: _____

Date: _____