ECFMG Continuation of J-1 Visa Sponsorship in Research Scholar / Non-Clinical Programs of Observation, Consultation, Teaching or Research

☐ Contract or Letter of Offer
The contract or letter of offer must specify start and end dates of the training year, specialty and subspecialty of the training program/pathway, training level and stipend. The applicant and an appropriate university official must sign the contract or letter of offer.

☐ Research Fellowship Program Description (if entering subspecialty training)
There are specific guidelines available on the ECFMG website for the fellowship description. (www.ecfmg.org)

☐ Application Form for Continuation of J-1 Visa Sponsorship
The applicant must complete and sign Section A. The program coordinator must complete Section B.

☐ Patient Contact Certification Statement
Official certification regarding level of patient contact (either incidental or no patient contact). See the ECFMG website for further guidance.

☐ Form I-644, Supplementary Statement for Graduate Medical Trainees
The exchange visitor must complete and sign Part 1; the program director or director of graduate medical education of the most recent (not proposed) host program must complete and sign Part 2 of the attached form.

☐ Form I-94, Arrival/Departure Record
The exchange visitor must submit a photocopy of the front and back of the most recent Form I-94 documenting admission to the United States in J-1 status valid for “Duration of Status – D/S”.

☐ ECFMG Administrative Fee (non-refundable)
DO NOT PAY ONLINE UNTIL YOU RECEIVE EMAIL THAT OIS TPL HAS COMPLETED THE FIRST PART OF THE APPOINTMENT PROCESS. To pay online, access OASIS on the ECFMG website. If you pay by check or money order, make the check or money order payable to ECFMG. Include your USMLE/ECFMG Identification Number, if applicable, on the check or money order.

☐ Statement of Need (from the central office of the Ministry of Health in the applicant’s country of most recent legal permanent residence)
See the EVSP Reference Guide on the ECFMG website for required format and wording. A certified, word-for-word English translation must accompany a non-English document.

☐ $100 OIS Processing Fee from the Department
The OIS office manager will complete the bottom portion of the IDT, please leave blank.

☐ EVNET Attestation
Attestation form must be completed and signed by the departmental/division coordinator and the chair.
SECTION A—To Be Completed by J-1 Exchange Visitor Physician

All information is REQUIRED. Please TYPE or PRINT.

USMLE®/ECFMG® Number: ____________

"Enter all information EXACTLY as it appears on the passport."

1. Family Name:

2. Rest of Name:

3. Health and Accident Insurance: I confirm I will maintain required health and accident insurance for myself and all J-2 dependents while sponsored. If the insurance is not a part of my hospital training benefits package, then I will purchase private coverage.

Name of Insurance Company:

4. Answer both of the following questions. Have you applied for either:
   a. U.S. Permanent Resident Status ("Green Card")? Y / N
   b. Waiver of the two-year home residence requirement? Y / N

If yes to either or both, please elaborate on the status of the application(s).

5. Statement of Educational Objective. Describe your overall training plans as a J-1 exchange visitor physician and intended length of stay in the U.S.:

Exchange Visitor Certification: I hereby certify that the information in this application is true and accurate to the best of my knowledge. I have read the EVSP Reference Guide and understand the obligations of J-1 sponsorship. I hereby authorize ECFMG to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any federal, state, or local governmental department of agency, to any hospital or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information.

Signature of Exchange Visitor Physician Date

E-Mail:
Tel: __________________ Fax: __________________
Residential Address:

SECTION B—To Be Completed by Training Program Liaison

All information is REQUIRED. Please TYPE or PRINT.

6. Host Institution:

ACGME Institution ID: ________ — ________ ________ ________ (if applicable)

Institution Name:

Institution Address:

Medical School Affiliation:

7. Training Program:

Level of Patient Contact: ☐ No Patient Contact OR ☐ Incidental Patient Contact

Specialty / Subspecialty:

Program Address. Federal regulations require ECFMG to report the exchange visitor’s site of training activity to the U.S. Government. Enter the physical street address:

8. Training Detail from Annual Contract:

Start Date ______ / ______ / ______ End Date ______ / ______ / ______ (m/d/y)

Training Level _____________ Hospital Stipend $ _____________

Other Funding Source and Amount, if applicable:

Submit documentation from the funding source certifying amount in US Dollars:

Training Program Liaison Certification: I hereby certify that the information I have provided is true and accurate to the best of my knowledge. I have read the EVSP Reference Guide and understand the obligations of hosting a J-1 exchange visitor physician.

Rev: OCT 2008
Application for J-2 Dependent Visa Sponsorship

The Educational Commission for Foreign Medical Graduates (ECFMG®) is authorized to sponsor the alien spouse and dependent unmarried minor children of the J-1 exchange visitor physician.

Please complete the following information and certify that you have obtained the required health and accident insurance for each J-2 dependent. Agencies of the U.S. Government require biographic details and spellings of all visa-related documents to match exactly. Attach a copy of the name page from each dependent’s passport.

To Be Completed by Applicant J-1 Exchange Visitor Physician
All information is REQUIRED. Please TYPE or PRINT.

J-1 Exchange Visitor Physician

1. USMLE®ECFMG® Number: ___________ ___________ ___________ ___________

2. Name: ____________________________________________________________

Federally Mandated Insurance Requirements

Exchange Visitors are required to obtain insurance which provides: (1) medical benefits of $50,000 per accident or illness, (2) a maximum $500 deductible per accident or illness, (3) medical evacuation benefits of $10,000, and (4) repatriation benefits of $7,500.

ECFMG will purchase on behalf of Exchange Visitors and their dependents under ECFMG sponsorship medical evacuation and repatriation of remains insurance (numbers 3 and 4 listed above) at the prescribed levels as stipulated in the U.S. Code of Federal Regulations governing Exchange Visitor Programs. Exchange Visitors and their dependents are required to obtain health and accident insurance (numbers 1 and 2 listed above) at the prescribed levels of coverage. Exchange Visitors who willfully fail to comply with insurance regulations cannot be sponsored by ECFMG. (22 CFR § 62.14)

3. Health and Accident Insurance: I confirm I will maintain required health and accident insurance for myself and all J-2 dependents while sponsored. If the insurance is not a part of my hospital training benefits package, then I will purchase private coverage. ____________________________________________________________

= Name of Insurance Company _________________________________________

Exchange Visitor Certification: I hereby certify that the information in this application is true and accurate to the best of my knowledge. I have attached passport copies.

X___________________________________________________________  Date __________________________

Signature of Exchange Visitor Physician

E-Mail: _______________________________________________________

Home Tel: __________________ Fax: _____________________________

Residential Address: __________________________________________

______________________________ ____________________________

______________________________ ____________________________

SPOUSE Verify details with the passport. Attach a copy of the passport name page.

Family Name: ________________________________________________

Rest of Name: _______________________________________________

Gender: M / F Date of Birth: ___ / ___ / ______ (mm/dd/yyyy)

Place of Birth (City, Province, Country):

____________________________________________________________

Country of Citizenship: Dual citizens must specify which passport will be used when traveling:

____________________________________________________________

Country of Most Recent Legal Permanent Residence:

Spouse's USMLE®ECFMG® Number: ___________ ___________ ___________ ___________

(If applicable)

CHILD Verify details with the passport. Attach a copy of the passport name page.

Family Name: ________________________________________________

Rest of Name: _______________________________________________

Gender: M / F Date of Birth: ___ / ___ / ______ (mm/dd/yyyy)

Place of Birth (City, Province, Country):

____________________________________________________________

Country of Citizenship: Dual citizens must specify which passport will be used when traveling:

____________________________________________________________

Country of Most Recent Legal Permanent Residence:

______________________________ ____________________________

______________________________ ____________________________

Additional children may be listed on a second form.

ECFMG recommends that you include U.S.-born children to assure coverage of repatriation of remains and medical evacuation insurance.

Submit this form and passport copies
With the Application for J-1 Visa Sponsorship
Or to
ECFMG - Exchange Visitor Sponsorship Program
3624 Market Street, Philadelphia, PA 19104-2685 USA
Tel (215) 823-2121 Fax (215) 366-3766

Rev OCT 2008