New Jersey Department of Health
NEW JERSEY CONRAD 30 PROGRAM

APPLICATION REQUIREMENTS

All documents must contain the case number assigned by the U.S. Department of State.
To obtain a case number from the U.S. Department of State, the application (DS-3035) can be found at:
https://j1visawaiverrecommendation.state.gov/

The following information must be provided with the application:

1. **CRAD-1 Required Application Enclosure.** The J-1 physician must initial that each required enclosure has been included in the application package and submitted in order.

2. **CRAD- 2 Cover Form.** The application must include brief information related to the sponsoring agency, proposed practice site(s), and information of the J-1 Physician.

3. **CRAD-3 Flex Justification Form (If applicable).** Practice sites that do not qualify as a HPSA, MUA, or MUP may apply for a Flex Slot. To be qualified for a Flex Slot, the applicant must demonstrate the practice site/physician will be treating residents within a federally designated area.

4. **CRAD-4 Facility Information.** The application must include information about the sponsoring agency and describe the practice site's program including the type of practice and the percentile of patients served by type of medical insurance. Include the site hours of operation and the weekly staffing schedule for the J-1 physician. The unique qualifications, cultural match, and experience to meet the service area indigent population health care needs should also be described.

5. **CRAD-5 Physician Waiver Statement.** The J-1 physician must sign and date the statement that avers they do not have a pending, nor are submitting, another application request to any United States Government department or agency, or any other State Department of Public Health during the pendency of this application with the New Jersey Department of Health. The J-1 physician must also sign and date that they attest that their medical license has never been suspended or revoked and that they are not subject to any criminal investigation or proceedings by any medical licensing authority.

6. **CRAD-6 Health Facility Agreement.** The Sponsoring Agency Contact for the facility or practice sponsoring the physician must initial the New Jersey's Conrad 30 Program requirements.

7. **CRAD-7 Physician Affidavit and Agreement.** In presence of a Notary Public, the J-1 Physician must provide a signature and initial next to each requirement of the New Jersey's Conrad 30 Program that they understand and acknowledge the terms and conditions of the agreement.

8. **Letter from Facility.** The Sponsoring Agency Contact of the facility must submit a brief cover letter requesting that the NJ Department of Health, as an Interested Government Agency, recommend the applicant to the U.S. Department of State and U.S.C.I.S for waiver of the home residency requirement as part of the New Jersey Conrad 30 Program. The letter should also state that the Sponsoring Agency Contact has read, initialed all the requirements, and signed the sponsor's agreement.

9. **DS-3035 Waiver Recommendation Application Data Sheet.** The request must include a completed, legible copy signed by the physician. A completed application would include the generated Third Party Barcode Page, Waiver Review Division Barcode Page, and Statement of Reason.

10. **Statement of Reason.** The J-1 Physician should provide a statement as to why they are applying for a waiver of the 212(e) two-year foreign requirement, including why they want to provide care to underserved populations.

11. **DS-2019 Certificate of Eligibility for Exchange Visitor Status.** The request must include a copy of the DS-2019 "Certificate of Eligibility for Exchange Visitor Status" form. Information on how to obtain this form can be found at: https://j1visa.state.gov/participants/how-to-apply/about-ds-2019/

12. **USCIS I-94 form.** The request must include a copy of the U.S. Citizenship and Immigration Services I-94 form. The form can be obtained at: https://i94.cbp.dhs.gov/I94/#/home

APPLICATION REQUIREMENTS

13. **HPSA/MUA/MUP Evidence.** Documentation must be provided that the J-1 physician agrees to practice in a geographic area, facility, or population that is designated by the Secretary of Health and Human Services as having a shortage of health care professionals (HPSAs) or lack of access to health care services (MUA/Ps). If applying for a Flex Slot, complete the Flex Justification Letter. To verify that your facility is in a shortage area, please use the following link and submit within application: https://data.hrsa.gov/tools/shortage-area/by-address

14. **Employment Contract.** The application must include an executed employment contract that satisfies *8 U.S.C. § 1184(l) and 22 CFR 41.63(e)(3)*. The contract shall not include a non-compete clause against the J-1 physician.

    The contract must specify the following:
    a. The name and address of the sponsoring health care facility;
    b. A statement that the physician agrees to meet the requirements set forth in Section 214(I) of the Immigration and Nationality Act;
    c. The physician must agree to work at the health care facility in which he/she is employed for no less than three (3) years;
    d. The physician must agree to practice medicine for a minimum of forty (40) hours per week in the designated geographic area or federally designated Health Professional Shortage Areas;
    e. The specific geographical area in which the applicant will practice medicine and;
    f. The physician must agree to begin employment at such facility within ninety (90) days of receiving a federally approved waiver
    g. Documentation must be provided to show that the J-1 physician will receive a salary and benefits equal to the income of a comparably qualified physician of the organization, and that is consistent with the prevailing wage in the geographic area.

15. **Physician Curriculum Vitae.** The application must contain a complete and current vitae of the physician.

16. **New Jersey Medical License.** Physicians must provide a copy of their current New Jersey medical license. If the New Jersey medical license is pending at the time of the application submission, proof of the pending license application must be submitted.

17. **DHS Form G-28.** This form is used to establish the eligibility of an attorney or accredited representative to represent a client in an immigration matter before U.S. Department of Homeland Security. The form can be obtained at: https://www.uscis.gov/g-28

18. **No Objection Letter (If required).** If the J-1 physician's medical education/training was funded by the physician's home government, the waiver application request must include a copy of the "no objection" letter from the home government. If there was no funding provided by the J-1 physician's home government, this must be indicated on the Physician Agreement.

19. **Facility Sliding Fee Scale.** Health services must be provided on a sliding fee scale to persons whose income falls below 250 percent of the federal poverty level or at no charge for persons unable to pay for these services. A copy of the sliding fee scale must be provided.

20. **Three Letters of Recommendation.** J-1 Physician must submit three letters of recommendation from medical professionals personally familiar with the physician's qualifications, work, and personal integrity.

21. **Residency/Fellowship Certificates.** Copies of all internship, residency, and fellowship certificates, or a signed letter indicating anticipated completion date of such a program, must be also provided.

22. **Recruitment Efforts for Physician Type.** A comprehensive summary of recruitment efforts to identify a qualified and interested board eligible or certified U.S. physician for the same job that is the object of the J-1 visa waiver request. Documentation of these efforts must include, as applicable, copies of job postings and job specifications.

New Jersey Department of Health
NEW JERSEY CONRAD 30 PROGRAM

APPLICATION REQUIREMENTS

APPLICATION SUBMISSION

A PDF version must be emailed to NJConrad30@doh.nj.gov
Additionally, an original and one unbound copy of the application must be submitted to:
New Jersey Department of Health
Office of Primary Care and Rural Health
Attention: NJ Conrad 30 Program
55 North Willow Street, 5th Floor
PO Box 355
Trenton, NJ 08625-0355

Every item requested in the application and guidelines should be clearly labeled, and in the order listed on the CRAD-1 Form. All fields in requested forms must be completed for the Department to be able to process an application. J-1 visa waiver applications that do not comply with the required information and documentation, including attachments and enclosures, will be returned to the applicant. If you have any questions, please contact the Office of Primary Care and Rural Health at (609) 847-9310.

The submission of a J-1 visa waiver application does not ensure that the Department will recommend a waiver. The Department reserves the right to recommend or decline a request for a waiver.

New Jersey Department of Health
APPLICATION FOR NJ CONRAD 30 PROGRAM

REQUIRED APPLICATION ENCLOSURES

The requesting applicant physician must initial that each required enclosure has been included in the application package for review by the Department Health. The application package must be submitted in order as below.

Initial

_____ Case File Number **[all documents must include a U.S. Department of State (DOS)-assigned number]**

_____ CRAD-1 Required Application Enclosures

_____ CRAD-2 Cover Form

_____ CRAD-3 Flex Justification Form **(If Applicable)**

_____ CRAD-4 Facility Information

_____ CRAD-5 Physician Waiver Statements

_____ CRAD-6 Health Facility Agreement

_____ CRAD-7 Physician Affidavit and Agreement

_____ Letter From Employer

_____ DS-3035 Waiver Recommendation Application Data Sheet

_____ Third Party Barcode Page and Waiver Review Division Barcode Page

_____ Statement of Reason

_____ All DS 2019 Forms and INS Forms 1-94

_____ HPSA/MUA/MUP Evidence for Each Practice Site

_____ Executed Employment Contract

_____ Physician Curriculum Vitae

_____ Copy of New Jersey Medical License

_____ G-28 Form Notice of Entry of Appearance

_____ No Objection Letter **(If Applicable)**

_____ Facility Sliding Fee Scale

_____ Three (3) Letters of Recommendation

_____ Copy of All Residency/Fellowship Certificates or a signed letter indicating anticipated completion date

_____ Copies of Recruitment Efforts for Physician Type

A pdf version must be mailed to NJConrad30@doh.nj.gov
Additionally, an original and one unbound copy of the application must be submitted to:
New Jersey Department of Health
Office of Primary Care and Rural Health
Attention: NJ Conrad 30 Program
55 North Willow Street, 5th Floor
PO Box 355
Trenton, NJ 08625-0355

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New Jersey Department of Health
Community Health Services
Office of Primary Care and Rural Health

SPONSORING AGENCY & PRACTICE SITE INFORMATION

1. Name of Sponsoring Agency:		
2. Name of Practice Site:		
3. Address:		
4. County:	5. Type of Designation: ☐ HPSA ☐ MUA/P ☐ N/A*	6. HPSA ID - MUA/P ID Number:
**If Practice site location is not a HPSA or MUA/P, Please Complete the (Flex Justification Form)*		

Secondary Practice Site Information (if applicable)

7. Name of Practice Site:		
8. Address:		
9. County:	10.Type of Designation: ☐ HPSA ☐ MUA/P ☐ N/A*	11. HPSA ID - MUA/P ID Number:
**If Practice site location is not a HPSA or MUA/P, Please Complete the (Flex Justification Form)*		

J-1 Visa Physician Information

12. Name of Physician:	
13. Date of Birth:	14. Gender:
15. Country of Birth:	16. Country of Legal Permanent Residence:
17. Discipline/Specialty:	18. Subspeciality (if applicable):
19. Describe and provide statistics that demonstrate the J-1 Physician's Specialty/Subspeciality is greatly needed in practice service area:	

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New Jersey Department of Health
Community Health Services
Office of Primary Care and Rural Health

FLEX SLOT APPLICATION FORM

1. Name and Address of Practice Site:	
2. Nearest HPSA / MUA/P ID:	3. City & Zip Code of Nearest HPSA / MUA/P:
4. Number of Miles From Nearest HPSA / MUA/P:	5. Number or Percent of HPSA / MUA/P Residents Served (*for the last fiscal year*):
6. Describe the medical needs of the population of patients served that reside in the surrounding HPSA / MUA/P, as it applies to the J-1 Physician's discipline:	
7. Additional Information:	

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New Jersey Department of Health
Community Health Services
Office of Primary Care and Rural Health

APPLICATION FOR NJ CONRAD 30 PROGRAM
PRACTICE SITE INFORMATION

Complete a separate form for additional practice site(s).

Physician Name			
NPI		NJ Medical License Number	

SPONSORING AGENCY INFORMATION

Name of Sponsoring Agency			
Street Address			
City	Zip Code	County	State
Name of Sponsoring Agency Contact			
Title		Telephone Number	

PRACTICE SITE INFORMATION

Street Address			
City	Zip Code	County	State
Practice Site NJ Health Facility License Number			
Medicaid Provider Number		Medicare Provider Number	

Type of Practice

☐ Public ☐ Private Non-Profit ☐ Private for Profit ☐ Community/Migrant Health Center ☐ Hospital-based Clinic
☐ Private Practice ☐ Group Practice ☐ Health Department ☐ Other (specify): _____

Percent of Practice Site Active Clients with Incomes at or Below 250% of Federal Poverty Level

Age Group	* Medicaid	* Medicare	+ Sliding Fee Scale	Commercial
0 – 18 Years	%	%	%	%
19+ Years	%	%	%	%

*This includes Medicaid/Medicare fee-for-service and managed care.
+Sliding Fee Scale would include clients with no insurance coverage (uninsured).

Day of Week	Practice Site Hours	Physician Work Hours
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

ADDITIONAL PHYSICIAN INFORMATION

Describe the J-1 Physician's unique qualifications, cultural match, and experience to meet the service area indigent population health care needs

New Jersey Department of Health
APPLICATION FOR NJ CONRAD 30 PROGRAM
PHYSICIAN WAIVER STATEMENTS

DECLARATION OF PENDING INTERESTED GOVERNMENT AGENCY

I, _____ hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1001, that I do not now have pending nor am I submitting during the pendency of this request, another request to any United States Government department or agency or any State Department of Public Health, or equivalent, other than the New Jersey Department of Health to act on my behalf in any matter relating to a waiver of my two-year-home-country physical presence requirement.

_____ _____
Physician Signature Date

MEDICAL LICENSE AFFIDAVIT

I, _____ hereby affirm, that to the best of my knowledge, my medical license has never been suspended or revoked and that I am not subject to any criminal investigation or proceedings by any medical authority.

_____ _____
Physician Signature Date

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New Jersey Department of Health
APPLICATION FOR NJ CONRAD 30 PROGRAM

HEALTH PRACTICE SITE AGREEMENT

The New Jersey Department of Health, hereinafter known as the (Department), is committed to assisting all residents to have access to quality, affordable health care. Accordingly, the Department is prepared to consider recommending a waiver of the foreign residence requirement on behalf of physicians holding J-1 Visas under certain conditions. Therefore, the additional requirements are deemed necessary to support our Conrad 30 Program.

The Sponsoring Agency Contact for the facility or practice sponsoring the physician **must initial all** the New Jersey's Conrad 30 Program requirements.

Initial	Program Requirement
_____	Practice agrees to comply with all the Program requirements set forth in this Agreement and guidelines.
_____	Physician request is sponsored by a practice located in a Health Professional Shortage Area (HSPA), Medically Underserved Area (MUA), Medically Underserved Population (MUP), or serve a population of patients that reside in an underserved area as designated by the Secretary of U.S. Department of Health and Human Services.
_____	The physician has agreed to provide health services for at least forty (40) hours a week at the site(s) named in this request for a minimum of three years. Travel or on-call time is not included in the 40 hours required by this paragraph.
_____	The practice sponsoring the physician agrees to provide health services to individuals without discriminating against them because (a) they are unable to pay for those services or (b) payment for those health services will be made under Medicaid and Medicare. The practice will charge persons receiving services at the usual and customary rate prevailing in the HPSA in which services are provided, except charges will be on a sliding fee scale for persons at or below 250 percent of poverty or at no charge for persons unable to pay for these services. Persons with third party insurance will be charged to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges.
_____	The practice has made a reasonably good faith effort to recruit a U.S. physician for the job opportunity in the same salary range without success during the last 3 months immediately preceding this request for waiver. Recruitment efforts were through a number of appropriate sources most likely to bring responses from able, willing, qualified and available U.S. physicians.
_____	The attached executed employment contract with the physician does not contain a restrictive covenant or non-compete clause which prevents or discourages the physician from continuing to practice in any HPSA, MUA, or MUP approved site after the period of obligation under this policy has expired.
_____	The physician has completed a residency in one of the following specialties: family practice, general pediatrics, obstetrics, gynecology, internal medicine, psychiatry, or other_____ and is dutifully licensed by New Jersey Board of Medical Examiners (or in the process of obtaining a license).
_____	The physician has not been "out of status" (as defined by the Immigration and Naturalization Service of the United States Department of Justice) for more than six (6) months since receiving a visa under 8 U.S.C. 1182 (j) of the Immigration and Nationality Act, as amended.
_____	The physician has signed and notarized the Department's "Physician J-1 Visa Waiver Affidavit and Agreement" and agrees to comply with the terms and conditions set forth in that document and Program guidelines.
_____	Practice understands that all requests recommended by the Department as an "Interested Government Agency" and approved subsequently by the Immigration and Naturalization Service of the United States Department of Justice is subject to an initial review and annually thereafter for compliance with New Jersey Conrad 30 Program policy, guidelines, and applicable federal/state laws.

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New Jersey Department of Health
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HEALTH PRACTICE SITE AGREEMENT

Initial	Program Requirement
_____	A "No Objection" letter ☐ is or ☐ is not required from the physician's country's home government. If required, the letter has been submitted within the application.
_____	The physician has signed the Declaration of Pending Interested Government Agency and Medical License Affidavit statements.
_____	Practice understands it has sole responsibility for ensuring the physician has proper medical credentials and the Department has no responsibility with respect to the physician's eligibility for change of non-immigration status or work authorization.

I certify that the application information provided to the Department of Health for purpose of determining whether it will act as an "Interested Government Agency" is true and correct as of the date set forth opposite my signature. I further understand that if the facility/practice does not respond to the Department staff seeking information and/or clarification of information in the application, the application will be returned for resubmission.

Sponsoring Agency Contact:

Name	Title
Signature	Date

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New Jersey Department of Health
APPLICATION FOR NJ CONRAD 30 PROGRAM

PHYSICIAN AFFIDAVIT AND AGREEMENT

I, _____, being duly sworn, hereby request the New Jersey Department of Health, hereinafter known as the (Department), to review my application for the purpose of recommending waiver of the foreign residency requirement set forth in my J-1 Visa, pursuant to the terms and conditions as follows:

1. 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 New Jersey, the Department, and any and all State employees from any action or lack of action made in connection with this request.

2. I further understand and acknowledge that the entire basis for the consideration of my request is the Department's desire to improve the availability of health services in areas designated by the Secretary of U.S. Department of Health and Human Services as Health Professional Shortage Areas (HPSA), Medically Underserved Areas (MUA), Medically Underserved Populations (MUA), or facilities that serve a population of patients residing in a federally designated underserved area in New Jersey.

3. I understand and agree that in consideration for a waiver, which eventually may or may not be granted, I shall render health services to patients, including the indigent, for a minimum of forty (40) hours per week at the site(s) named in this request. Such service shall commence not later than three months (90 days) after I receive notification of approval by United States Immigration and Naturalization Service (INS) and shall continue for **a minimum of three (3) years as required by State policy guidelines**.

4. I have incorporated all terms of this Physician J-1 Visa Waiver Affidavit and Agreement into the executed employment contract attached to this request.

5. I further agree that my executed employment contract with the practice does not contain any provision which modifies or amends any terms of the Program guidelines for New Jersey and this Physician J-1 Visa Waiver Affidavit and Agreement.

6. I agree to accept assignment under Section 1842 (b) (3) (ii) of the Social Security Act as full payment made under Part B of Title XVIII (Medicare). I further agree to provide services to individuals entitled for medical assistance under Title XIX of the Social Security Act (Medicaid) that is administered by the State agency.

7. I understand and agree to provide health services to individuals without discriminating against them because (a) they are unable to pay for those services or (b) payment for those health services will be made under Medicaid and Medicare. I will charge persons receiving services at the usual and customary rate prevailing in the HPSA, MUA, or MUP in which services are provided, except charges that will be on a sliding fee scale for persons at or below 250 percent of poverty or at no charge for persons unable to pay for these services. Persons with third party insurance will be charged to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges.

8. I am ☐ or ☐ am not required to submit a "No Objection" letter as my foreign medical education was not funded by my home country's government. If required, I have submitted the letter within this application.

9. I have not been "out of status" (as defined by the Immigration and Naturalization Service of the United States Department of Justice) for more than six (6) months since receiving a visa under 8 U.S.C. 1182 (j) of the Immigration and Nationality Act, as amended.

10. I understand the Declaration Of Pending Interested Government and Medical License Affidavit and signed both statements.

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New Jersey Department of Health
APPLICATION FOR NJ CONRAD 30 PROGRAM

PHYSICIAN AFFIDAVIT AND AGREEMENT

11. I understand that if I fail to fulfill the terms of my employment contract with the practice named in the waiver application, I become subject to the two-year foreign residence, and is ineligible to apply for an immigrant visa, permanent residence, or any other change of immigrant status until the two-year foreign residence requirement is met.

12. I expressly understand and acknowledge the scope of New Jersey Conrad 30 Program guidelines and all the information contained in my application request submitted by

    _____ on my behalf.
    (Name of Attorney/Legal Firm)

I declare under penalties of perjury that all the information provided to the Department of Health for purposes of determining whether it will act as an "Interested Government Agency" is true and correct.

Signature of Physician	Date

Subscribed and sworn before me this

_____ day of _____, 20____

_____ **(Notary Public)**
(Signature)

DOS Case Number: _____