New Jersey Department of Health
APPLICATION FOR J-1 VISA WAIVER / STATE CONRAD 30 PROGRAM

SECTION 4-2
PHYSICIAN J-1 VISA WAIVER 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 primary medical care in areas designated by the Secretary of U.S. Department of Health and Human Services as Health Professional Shortage Areas (HPSA) in New Jersey.

3. I understand and agree that in consideration for a wavier, which eventually may or may not be granted, I shall render primary medical care services to patients, including the indigent, for a minimum of forty (40) hours per week within a designated HPSA in New Jersey. 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 facility/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 in which services are provided, except charges will be on a sliding fee scale for persons at or below 200 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 not required to submit a "No Objection" letter as my foreign medical education was not funded by my home country's government.

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.

SECTION 4-2
PHYSICIAN J-1 VISA WAIVER / STATE CONRAD 30 PROGRAM AFFIDAVIT AND AGREEMENT (CONTINUED)

11. I expressly understand I am to provide written notification of the specific location and nature of my practice to the Department's Office of Policy and Strategic Planning at the time **I receive notification from INS and** I commence rendering services in the State HPSA. I further understand and agree that my relocation from a site approved in the application request to a new site must be approved by the Department in writing prior to the move.

12. I understand and agree to submit an initial and annual reports to the Department upon approval of the waiver request according to the timeframes specified

13. I understand that if I fail to fulfill the terms of my employment contract with the facility/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.

14. I expressly understand and acknowledge the scope of New Jersey J-1 Visa Waiver / State Conrad 30 Program guidelines and all the information contained in my application request submitted by _____ on my behalf.
(Name of Facility/Practice)

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)