APPLICANT PHYSICIAN ASSURANCES FOR J-1 VISA WAIVER APPLICATIONS

Completion of this form satisfies the physician assurances required under U.S. Department of State regulations, 22 CFR 41.63. Failure to complete this form will result in an application being ineligible for a state recommendation for a J-1 visa waiver.

The foreign medical physician requesting this J-1 visa waiver recommendation, through the health care employer identified in the Wisconsin Department of Health Services, Health Care Employer Assurances for J-1 Visa Waiver Application, F-43006, assures that each of the following statements are factual.

The applicant physician must initial each statement below, and must sign and date at the bottom of this form.

_____ I agree to the contractual requirements for J-1 visa waiver physicians set forth in federal immigration law at Public Laws 103-416 and 107-273.

_____ I agree to provide primary care/medical services for the health care employer for a minimum of 40-hours per week, with at least 32-hours direct patient care, for a period of three years, and only at the practice address specified in the employment agreement submitted with this application.

_____ 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 United State Government department or agency or any State Department of Public Health, to act on my behalf in any matter relating to a waiver of my two-year home-country physical presence requirement.

_____ I agree to begin working for the health care employer within 90-days of the effective date of the J-1 visa waiver.

_____ I the applicant physician for whom the health care employer is submitting this application, do assure that each of these statements is factual.

NOTE: There are federal sanctions for failure to comply with the Immigration and Nationality Act Requirements. See Wisconsin guidelines For state recommendations for J-1 visa waivers available from the following Wisconsin Department of Health Services web page:
https://www.dhs.wisconsin.gov/primarycare/j-1visa/index.htm

Print Name of Applicant Physician

SIGNATURE – Applicant Physician	Date Signed