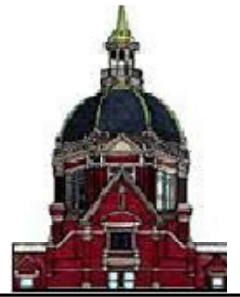




J-1 ECFMG Sponsorship at JHMI



PACKET #3

Use ONLY for
International Physicians
Who Are
JOINING
your **ACGME-accredited**
Clinical Training Program
From **Overseas**

PHOTOCOPY THE PACKET AS NEEDED FOR ALL APPLICABLE
INTERNATIONAL PHYSICIANS.
Questions? Contact OIS at 5-3371 or visit us on the 1st floor of Reed Hall



TO: J-1 Exchange Visitor Physicians
ECFMG Training Program Liaisons (TPLs)

FROM: Exchange Visitor Sponsorship Program (EVSP)

DATE: October 27, 2008

RE: DHS SEVIS Fee

Effective October 27, 2008, the non-refundable fee charged by the US Department of Homeland Security (DHS) to initial J-1 applicants will increase to \$180. The fee is also required for applicants changing status to J-1 and applicants seeking J-1 reinstatement. J-2 dependents are exempt from this fee. The US government collects this fee to cover its cost of implementing the Student and Exchange Visitor Information System (SEVIS) database for monitoring students and exchange visitors in the United States.

The SEVIS fee may be paid through the Internet at www.FMJfee.com by completing the electronic version of Form I-901 and submitting a credit card payment. Payment confirmation will be available immediately and should be printed for use as a receipt when applying for J-1 status. Additionally, a receipt will be sent by postal mail to the address indicated on the payment form.

The SEVIS fee must be paid in full before appearing for a visa interview. For those initial applicants who do not need a J-1 visa to enter the US, the fee must be paid in full before arriving at the US port-of-entry. Applicants will be expected to present a SEVIS fee payment receipt for the visa interview at the embassy, or at the US port-of-entry. If, for some reason, the printed or mailed receipt is not available to the applicant before the interview at the embassy or port-of entry, the applicant can appear for the interview as long as the SEVIS payment has been processed by DHS. For information on the SEVIS fee and detailed payment instructions, visit www.FMJfee.com.

Please note the DHS fee (\$180) is separate from and in addition to the ECFMG-EVSP administrative fee. The SEVIS fee must be paid directly to DHS.

Please contact the ECFMG-EVSP office with any questions regarding the SEVIS fee.

CHECKLIST for INITIAL J-1 VISA SPONSORSHIP in ACGME-ACCREDITED CLINICAL TRAINING PROGRAMS

This checklist outlines the basic requirements to apply for J-1 visa sponsorship to participate in an Accreditation Council for Graduate Medical Education (ACGME)-accredited training program or a program leading toward certification offered by a member board of the American Board of Medical Specialties (ABMS). Identify all documentation with the applicant's USMLE®/ECFMG® number. Copied materials are acceptable; however, ECFMG reserves the right to examine the original document. Application submission requires coordination between the applicant and the Training Program Liaison (TPL) at the host institution. Submit all requirements in one package and allow four to six weeks for processing. Incomplete submissions will cause delay. ECFMG will communicate any deficiencies and/or requests for additional documentation through the TPL. Retain a copy of all materials.

ECFMG CERTIFICATION PREREQUISITE. International Medical Graduates must hold a Standard ECFMG Certificate without expired examination dates, if applicable. See *Validity of Examinations for Entry into Graduate Medical Education in the ECFMG Information Booklet*, available on the Publications page of the ECFMG website at www.ecfm.org/pubshome.html.

- 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 hospital official must sign the contract or letter of offer.
- FELLOWSHIP PROGRAM DESCRIPTION (if entering subspecialty training).** The fellowship description must follow attached guidelines.
- APPLICATION FORM FOR INITIAL SPONSORSHIP.** The applicant must complete and sign Section A. The TPL must review Section A and complete and sign Section B.
- 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.
- CURRENT CURRICULUM VITAE (C.V.).** The C.V. must detail the applicant's education and professional history to date.
- COPY OF PASSPORT NAME PAGE(S).** Submit a copy of the passport name page for the applicant and each dependent.
- \$275 ADMINISTRATIVE FEE (non-refundable).** Access OASIS on the ECFMG website (www.ecfm.org) to pay the fee.
- ADDITIONAL DOCUMENTATION (if applicable)**
 - Copies of Form(s) IAP-66 and/or DS-2019 if the applicant has previously held J-1 visa status.
 - Proof of country of most recent legal permanent residence if this differs from country of citizenship.
 - Official documentation of funding source, terms, amount, and U.S. dollar equivalent if other than or in addition to hospital training stipend.
- RETURN AIRBILL FOR EXPEDITED DELIVERY TO THE TPL (optional, but recommended).** If the application is approved, ECFMG will issue Form DS-2019, Certificate of Eligibility for Exchange Visitor (J-1) Status, to the TPL via first-class U.S. mail. ECFMG is not authorized to release the Form DS-2019 directly to the applicant. To expedite delivery, it is recommended that a *prepaid/preaddressed courier service airbill* be included with the application. Time constraints prevent EVSP staff from addressing airbills.

ADDITIONAL REQUIREMENTS FOR GRADUATES OF LCME-ACCREDITED U.S. OR CANADIAN MEDICAL SCHOOLS

-
- COPY OF MEDICAL SCHOOL DIPLOMA.** A certified, word-for-word English translation must accompany a non-English document.
 - FULL-FACE PASSPORT-SIZE PHOTOGRAPH.** Original photo required, no faxes or photocopies.
 - If you do not have a USMLE/ECFMG Identification Number and/or cannot access OASIS, the application packet should be submitted without payment. Upon receipt of your application, ECFMG will send you OASIS registration instructions via e-mail.

*Thank you for your interest in ECFMG's Exchange Visitor Sponsorship Program.
For additional information, visit the ECFMG website at www.ecfm.org or contact EVSP at 215-823-2121.*



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 _____
Signature of Exchange Visitor Physician Date

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: _____

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) 386-9766

Guidelines for Fellowship Program Description

One requirement for ECFMG sponsorship in subspecialty training is submission of a detailed program description. ECFMG created the following as a guide for developing the program description to meet this sponsorship requirement. This outline is modeled after the format used in the American Medical Association's *Graduate Medical Education Directory* (the "Green Book"). Although there are no specific length requirements, program descriptions are typically 2-3 pages. All program descriptions must be prepared on official institutional letterhead, be signed by the program director, and *must* include the following information.

A. Program Demographics

1. Name of Host Institution
2. Program Specialty/Subspecialty
3. Program Address (Mailing)
4. Program Address (Physical location, if different from mailing)
5. Program Phone Number
6. Program Fax Number
7. Program E-mail
8. Program Director
9. Alternate Program Contact

B. Introduction

1. History. Identify how long the program has been in existence and include the number of individuals who have completed the training program since its inception.
2. Duration. Define an exact duration for the training program.
3. Prerequisite Training/Selection Criteria. Identify prerequisite training requirements and other selection criteria used in appointing candidate(s).
4. Goals and Objectives for Training. Define the educational purpose of the training program and intended goals of the training program.
5. Program Certifications. List any additional certifications or recognitions that the program may hold.

C. Resources

1. Teaching Staff. List the teaching staff involved in providing the educational experience and their supervisory responsibilities over the participant(s). It is not necessary to send a faculty member's Curriculum Vitae (C.V.).
2. Facilities. List all training sites where rotations are conducted.

D. Educational Program - Basic Curriculum

Describe the following elements of the training program:

1. Clinical and research components.
2. Participant's supervisory and patient care responsibilities.
3. Procedural requirements.
4. Didactic components.
5. If the program is more than 12 months in duration, please describe the progression in responsibilities by PGY level.

E. Evaluation

Describe the formal evaluation process used to assess the educational performance of program participants.

Example only. Do not print.

Example of Statement of Need Letter

The following is the exact wording that has been approved by the U.S. Secretary of Health and Human Services for the *Statement of Need*:

Name of Applicant for Visa: _____

There currently exists in (country) a need for qualified medical practitioners in the specialty of _____.

(Name of Applicant for visa) has filed a written assurance with the government of this country that he/she will return to his/her country upon completion of training in the United States and intends to enter the practice of medicine in the specialty being sought.

Include Stamp (or Seal and Signature) of issuing official of named country.

Include Date and Signature of Official of named country.

The Statement of Need must:

- Specify the **exact** specialty and/or subspecialty pursued.
- Be issued on government letterhead by the **central office** of the Ministry of Health in country of most recent legal permanent residence.
- Be accompanied by a certified English translation if letter is written in a foreign language.

The Statement of Need is required for all INITIAL applicants to ECFMG or if any of the following apply:

- The applicant is entering a new specialty or subspecialty
- The letter on file with EVSP will expire
- The letter on file with EVSP is institution-specific and a change in host institution is proposed

**Office of International Student,
Faculty, and Staff Services**

Reed Hall, 1st Floor
 1620 McElderry Street
 Baltimore, MD 21205
 (410)955-3371/FAX (410) 955-0871
www.hopkinsmedicine.org/intlsvcs

**The Johns Hopkins University
 School of Medicine**

REQUEST FOR CERTIFICATION FOR EXCHANGE VISITOR STATUS

In order to comply with the provisions of the U.S. Mutual Educational & Cultural Exchange Acts, the Responsible Officer, designated by the United States Department of State for the administration of the Johns Hopkins University (JHU) Exchange Visitor Program P-1-04644, is required to make certain determinations regarding the alien's eligibility for certification for Exchange Visitor Status prior to issuing the Form DS 2019. The attached form is the official process by which the JHU Medical Institutions (JHMI) determines an alien's suitability for participation in JHMI's J-1 Exchange Visitor Program (P-1-04644).

While the JHU School of Medicine wishes to maintain its international prominence in the postgraduate education, there is genuine confusion concerning the appropriate visa status for candidates applying for postgraduate degree programs, clinical and non-clinical training positions, employee positions, observer positions and faculty positions at the JHU School of Medicine. The local and federal regulations governing visa sponsorship have been subject to broad and often inappropriate interpretation. Therefore, please contact the Office of International Student, Faculty & Staff Services (OIS) with any questions you may have concerning a visa status for an incoming international visitor.

The Responsible Officer for all immigration-related matters is ultimately the Dean of the School of Medicine or his/her designee. The Dean of the School of Medicine has officially delegated this responsibility to the Director and other staff members of OIS. Faculty or administrators are not authorized to sign visa petitions or visa forms (such as the DS-2019). All interactions with private attorneys representing an employee, student, observer, trainee, visitor, faculty, etc. should be immediately referred to OIS at 410.955.3371.

PROCEDURES

- Complete the Request for Certification for Exchange Visitor Status, including the SEVIS fee payment section (see below). Be sure to include all financial information/proof and FedEx account number, as requested, on page 2.
- Obtain all required signatures on the request form.
- For initial certification and transfer applications only*, submit the entire information packet for approval to the School of Medicine, Office of Postdoctoral Programs, 733 N. Broadway (Broadway Research Building), Suite 147. (Phone: 410-955-3191)
- Upon approval, the Office of Postdoctoral Programs will forward the request form and this cover sheet concerning SEVIS fee payment to the OIS.

[Extension requests should be submitted directly to the OIS as they do not require Office of Postdoctoral Programs approval.]

THIS J-1Request Sheet is for ECFMG Applications ONLY!

The Johns Hopkins University School of Medicine
REQUEST FOR CERTIFICATION FOR EXCHANGE VISITOR STATUS

This is a request for (check one): Initial Certification Program Extension* Transfer* Amendent

*Please be advised that certain J-1 categories may remain in the U.S. for strictly limited periods of time which will vary according to specific circumstances. The Office of International Services will advise on a case by case basis.

SECTION A: *PLEASE ATTACH COPIES OF APPLICANTS PASSPORT I.D. PAGE

Salutation: Dr. Mr. Mrs. Ms. Male Female Single Married

Family Name _____ Given Name _____ Middle Name _____

SSN: _____ ITIN: _____ Date of Birth / /
mm dd yyyy

City of Birth: _____ Country of Birth: _____ Country of Citizenship _____

Country of Residence: _____ Occupation in Home Country: _____ Company/Institution Name: _____

Address in Home Country: Number and street _____

City _____ State/Province _____ Country _____ Postal Code _____

Phone: _____ / _____ E-Mail _____

U. S. Address: Number and street _____

City _____ State _____ Postal Code _____

Phone: _____ / _____ E-Mail _____

Address to which DS2019 Form is to be sent: (Note: can NOT be a post office box.) Number and Street _____

City _____ State/Province _____ Country _____ Postal Code _____

Phone: _____ / _____ E-Mail _____

SECTION B:

If the Exchange Visitor is currently in the United States, please complete the following:

Current Visa Status: _____ Current Sponsor/School: _____ Date of Initial Entry into U.S.: _____

(NOTE: If the Exchange Visitor is transferring to the JHMI from another institution, you must attach copies of all previous DS2019 Forms issued to him/her.)

SECTION C:

Doctoral/MD Degree Awarded by: _____ on _____
Name of School month/day/year

Date of Hopkins Appointment: From _____ to _____

Do anticipated activities include patient responsibility or direct patient contact? Yes No

Provide percentage of each year devoted to the following:

Teaching _____ Research _____ Coursework _____ Patient contact/care _____

School of Medicine Appointment Status(check one only):

Research Fellow Research Trainee Student (Degree Program: _____) Clinical Fellow (ECFMG# _____)

Faculty Resident/House Staff (ECFMG# _____) Observer Clinical & Research Fellow (ECFMG# _____)

Other (specify title): _____

(This Section MUST include a detailed description)

Describe the anticipated role of the Exchange Visitor including specific field of study (attach additional sheet if necessary):

Source of financial support:

Johns Hopkins (specify source & include budget number) _____ \$ _____
U.S. Government Agency (direct or indirect payment)* _____ \$ _____
The Exchange Visitor's Government (agency/branch name)* _____ \$ _____
International Organization (agency/organization name)* _____ \$ _____
Personal Funds (give donor's name if not self-supported)* _____ \$ _____
All other organizations providing support* _____ \$ _____

*If funding is a non-Hopkins source, you MUST attach appropriate documentation of funding sources (e.g., bank statements, copies of donor/sponsor letters, etc.).

SECTION D:

Number of Accompanying Family Members: _____ For each family member, please provide the following information:

Salutation: Dr. Mr. Mrs. Ms. Male Female Relationship _____ Date of Birth ____/____/____
mm dd yyyy
Family Name _____ Given Name _____ Middle Name _____
SSN: _____ ITIN: _____ City of Birth: _____
Country of Birth: _____ Country of Citizenship _____ Country of Residence: _____

Salutation: Dr. Mr. Mrs. Ms. Male Female Relationship _____ Date of Birth ____/____/____
mm dd yyyy
Family Name _____ Given Name _____ Middle Name _____
SSN: _____ ITIN: _____ City of Birth: _____
Country of Birth: _____ Country of Citizenship _____ Country of Residence: _____

Salutation: Dr. Mr. Mrs. Ms. Male Female Relationship _____ Date of Birth ____/____/____
mm dd yyyy
Family Name _____ Given Name _____ Middle Name _____
SSN: _____ ITIN: _____ City of Birth: _____
Country of Birth: _____ Country of Citizenship _____ Country of Residence: _____

SECTION E:

Department & Division Requesting Sponsorship (e.g., Department of Medicine, Department of Neurology):

Department: _____ Division: _____

Department Administrative Contact: Name _____ Address: Number and street _____
City _____ State _____ Postal Code _____
Phone: ____/____/____ Fax ____/____/____ E-Mail _____

Preceptor / Advisor Contact: Name _____ Address: Number and street _____
City _____ State _____ Postal Code _____
Phone: ____/____/____ Fax ____/____/____ E-Mail _____

To ensure prompt and accurate delivery of visa documents, you must provide your **FED EX ACCT #** : _____

Required Signatures

Preceptor / Advisor: _____ Date: _____
Department Director: _____ Date: _____
Postdoctoral Office: _____ Date: _____