Complete and check all applicable fields, corresponding boxes and enter all required information:

**Candidate’s Information:**

Candidate’s Full Name: Doctor’s first/last name

Residency Discipline: Residency type

Residency Timeframe: Start date to End date

Location of Residency: Name of school, State

Fellowship(s)/Specialty: Fellowship type if applicable or n/a

Fellowship(s) Timeframe1: Start date to End date

Location of Fellowship(s)1: Name of school, State

**Employer’s Information:**

Employer’s Full Name: Name of doctor’s employer/organization/administration

Employer’s Address: Employer/Organization mailing address, City, State Zip

Practice Site #1: Name of practice site #1

Practice Site #1 Address: Address of practice site #1

Number of Hours Candidate will practice at site to meet 40 hours per week: Number of Hours site#1

Select and input all that apply:

[ ]  Practice Site #1 HPSA (#HPSA#) [ ]  Practice Site #1 MUA (#MUA#) [ ]  Flex spot

[ ]  Federally Qualified Health Center (FQHC) [ ]  Tribal Health Center

[ ]  Rural Health Clinic (RHC) [ ]  Primary Care Clinic for a Rural Hospital

Practice Site #2\*: Name of practice site #2

Practice Site #2 Address: Address of practice site #2

Number of Hours Candidate will practice at site to meet 40 hours per week: Number of Hours site#2

Select all that apply:

[ ]  Practice Site #2 HPSA (#HPSA#) [ ]  Practice Site #2 MUA (#MUA#) [ ]  Flex spot

[ ]  Federally Qualified Health Center (FQHC) [ ]  Tribal Health Center

[ ]  Rural Health Clinic (RHC) [ ]  Primary Care Clinic for a Rural Hospital

More than two additional practice sites: [ ]  Yes [ ]  No

\*If additional practice sites, please copy and add all additional practice locations here or at end of form\*

**Official Legal Representative and Contact Person for Application:**

Contact Name: Office Contact Name (first/last)

Contact Mailing Address: Mailing Address City, State Zip Code

Contact e-mail: Official Contact E-Mail

Contact telephone: Official Contact Telephone Number

**Official Contact Person for Employment Verification and Site Information:**

Contact Name: Office Contact Name (first/last)

Contact Mailing Address: Mailing Address City State, Zip Code

Contact e-mail: Official Contact E-Mail

Contact telephone: Official Contact Telephone Number

Employer and Candidate, as identified above, seek a letter of support from the Physician Visa Waiver Program and requests the Division of Public and Behavioral Health to forward the J-1 Visa Waiver application to the U.S. Department of State as a State Health Agency request, per DS-3035. Employer and Candidate have agreed to comply with the duties set forth in Chapter 439A of the Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC) and to cooperate with the Physician Visa Waiver Program.

Employer and Candidates have provided all necessary information for review of this application by the Primary Care Council including the following:

[ ]  Copy of the contract between the Employer and Candidate;

[ ]  Copy of the Candidate curriculum vitae and passport pages;

[ ]  Letter from Employer: description of the Candidate’s qualifications, responsibilities and how this employment will satisfy important unmet health care needs within the designated area;

[ ]  Summation tables identifying the breakdown of patient visits billed by payment category;

[ ]  Documentation of employer recruitment efforts for US citizens for two months prior to submission of the application, UNLESS the requirement was waived for a rural employer with emergent needs;

[ ]  Long-range retention plans which include the following: CME benefit, competitive salary and paid time off.

[ ]  Copy of letter from the Nevada State Board of Medical Examiners (NSBME) acknowledging Candidate's application for medical licensure;

[ ]  INS Form *G-28* OR letter from a law office if the candidate has an attorney OR a statement that the applicant does not have an attorney;

[ ]  Copies of all *DS-2019’s* "Certificate of Eligibility for Exchange Visitor (J-1 Visa Waiver) Status" (INS form(s) *I-94* for the candidate and any family members; proof of passage of examinations required by Bureau of Criminal Investigation (BCI); transcripts for all 3 sections of *United States Medical Licensing Examinations* (USMLE); and certification from *Educational Commission for Foreign Medical Graduates* (ECFMG).

In signing below, an authorized representative of the Employer and the Candidate declares under penalty of perjury that all statements submitted with this application are true and accurate and this application complies with the requirements of NRS 439A.175 and NAC 439.730 including as follows:

**All practices sites where the Candidate will practice:**

[ ]  Are located in a federally designated Primary Care HPSA, MUA/P or a site approved by the state as a geographic exception or a flex slot (Public Law 108-441) to address the underserved;

[ ]  Accept Medicare, Medicaid assignment and Nevada Checkup;

[ ]  Offer a sliding discount fee schedule and a minimum fee based on family size & income; and

[ ]  Has a policy stating all patients will receive treatment, regardless of their ability to pay which is either posted at the site or provided to the patients.

**The contract between the Employer and the Candidate provides the following** (verify and enter missing data)**:**

[ ]  Candidate agrees to provide services during 3 -year waiver obligation;

[ ]  Candidate will provide services 40 hours per week minimum plus on-call time;

[ ]  The salary meets or exceeds the prevailing wage for that area and for physicians of that specialty as reported by the Foreign Labor Certification Center, Department of Labor, (<http://www.flcdatacenter.com>): Prevailing wage (FLC Median wage for Discipline type: $FLC Mean Wage/ Contracted wage $Contracted Base Wage only base pay

[ ]  The amount of time off for vacation, sick leave and for Continuing Medical Education is included. The employer shall maintain records to show the amount of time-off requested and the amount of time taken.

[ ]  Does not contain a “non-compete” clause that would prohibit the J-1 Visa Waiver physician from opening a new clinic or working in a clinic in that shortage area upon completing the three-year commitment;

[ ]  Conditions for termination of the contract, for both the physician and employer, are included. A “no-cause” termination is not allowed;

[ ]  Liquidated damages (suggested to be under $50,000) in the event that the physician or employer terminates the contract before three years is included in the contract - Employer $Employer liquidated $/or N/A/Physician $Physician liquidated $/or N/A;

[ ]  Agreement to begin employment at the stated practice site within 90 days of receiving a waiver from the United States Citizenship and Immigration Services (USCIS). During the 90 days, the physician must obtain the required licenses from the Nevada State Board of Medical Examiners, the Drug Enforcement Agency, the State Board of Pharmacy, and any other licenses as may be required for the physician to practice medicine in Nevada; and

[ ]  A statement that the physician agrees to meet the requirements set forth in section 214(I) of the Immigration and Nationality Act.

*Please note in accordance with NRS Chapter 239, all public records, the contents not otherwise declared by law to be confidential, shall be open for inspection or to obtain copies.*

By signing below, I hereby attest that the above requirements have been met and I hereby agree to abide by all the program policies and rules as described in NRS and NAC and as further required under the Rights and Responsibilities located at the Divisions website at: <http://dpbh.nv.gov/Programs/Conrad30/Conrad30-Home/>.

***Authorized Employer:***

**Employer Company/Business Name**

**Employer Representative Name (First/Last) Title**

**Employer Signature Date**

**NOTARY PUBLIC:**

State of:

County of:

Subscribed and Sworn before me on this day of , 20

Notary Signature

My Commission Expires:

***Candidate/Physician:***

**Candidate Name (First/Last) Title**

**Candidate Signature Date**

**NOTARY PUBLIC:**

State of:

County of:

Subscribed and Sworn before me on this day of , 20

Notary Signature

My Commission Expires: