



EDUCATIONAL COMMISSION FOR
FOREIGN MEDICAL GRADUATES

3624 Market Street
Philadelphia PA 19104-2685 USA
215-386-5900 | 215-386-9766 Fax
www.ecfm.org

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

FROM: ECFMG Exchange Visitor Sponsorship Program

DATE: December 17, 2009

RE: Increase in J-1 Sponsorship Application Fee

Effective January 1, 2010, ECFMG's J-1 sponsorship application fee will increase from \$200 to \$250. The charge for applications with payment received at ECFMG on or before December 31, 2009 will be \$200. The charge for applications with payment received at ECFMG on or after January 1, 2010 will be \$250.

ECFMG encourages applicants to pay the application fee through ECFMG's On-line Applicant Status and Information System (OASIS), which can be accessed through the ECFMG website at www.ecfm.org. Please note that the J-1 sponsorship application fee is **non-refundable**.

CHECKLIST for CONTINUATION of 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.

- 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 CONTINUATION OF J-1 VISA SPONSORSHIP.** The applicant must complete and sign Section A. The TPL must review Section A and complete and sign Section B.
- FORM I-644, SUPPLEMENTARY STATEMENT FOR GRADUATE MEDICAL TRAINEES (attached).** The exchange visitor physician must complete and sign Part 1; the program director or director of graduate medical education of the *most recent* (not proposed) host program must complete and sign Part 2 of the attached form.
- FORM I-94, ARRIVAL/DEPARTURE RECORD.** The Exchange Visitor must submit a photocopy of the front and back of the most recent Form I-94 documenting admission to the United States in J-1 status valid for "Duration of Status – D/S." Form I-94 may be attached to Form I-797, Notice of Action, issued by the U.S. Immigration and Naturalization Service or the U.S. Department of Homeland Security/Bureau of Citizenship and Immigration Services.
- \$250 ADMINISTRATIVE FEE (non-refundable).** To pay on-line, access OASIS on the ECFMG website (www.ecfm.org). If you pay by check or money order, make the check or money order payable to ECFMG. Include your USMLE/ECFMG Identification Number, if applicable, on the check or money order.
- 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.
- 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.

*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 Continuation of J-1 Visa Sponsorship in ACGME-Accredited Training Programs

SECTION B-To Be Completed by Training Program Liaison
All information is REQUIRED. Please TYPE or PRINT.

6. Host Institution:
ACGME Institution ID: _____
Institution Name: _____
Institution City, State: _____
Medical School Affiliation: _____

7. ACGME-Accredited Training Program:
ACGME Program ID: _____
Specialty/Subspecialty: _____
Program Address. Federal regulations require ECFMG to report the exchange visitor's site of training activity to the U.S. Government. Enter the physical street address:

8. Training Detail from Annual GME Contract:
Start Date ____/____/____ End Date ____/____/____
(mm/dd/yyyy) (mm/dd/yyyy)
Training Level _____ Hospital Stipend \$ _____
Other Funding Source and Amount, if applicable: _____
Submit documentation from the funding source confirming amount in U.S. dollars.

Training Program Liaison Certification: I hereby certify that the information I have provided is true and accurate to the best of my knowledge. I have read the EVSP Reference Guide and understand the obligations of hosting a J-1 exchange visitor physician.
X _____
Signature of Training Program Liaison (TPL) Date
TPL Name: _____
TPL Title: _____
E-Mail: _____
Tel: _____ Fax: _____
TPL Mailing Address: _____

SECTION A-To Be Completed by J-1 Exchange Visitor Physician
All information is REQUIRED. Please TYPE or PRINT.

USMLE®/ECFMG® Number: _____
Enter all information EXACTLY as it appears on the passport.
1. Family Name: _____
2. Rest of Name: _____
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
4. Answer both of the following questions. Have you applied for either:
a. U.S. Permanent Resident Status ("Green Card")? Y / N
b. Waiver of the two-year home residence requirement? Y / N
If yes to either or both, please elaborate on the status of the application(s).
5. Statement of Educational Objectives. Enter your specialty/subspecialty and duration of training.

Exchange Visitor Certification: I hereby certify that the information in this application is true and accurate to the best of my knowledge. I have read the EVSP Reference Guide and understand the obligations of J-1 sponsorship. I hereby authorize ECFMG to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any federal, state, or local governmental department or agency, to any hospital, or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information.
X _____
Signature of Exchange Visitor Physician Date
E-Mail: _____
Tel: _____ Fax: _____
Residential Address: _____



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

FORM I-644: SUPPLEMENTARY STATEMENT FOR GRADUATE MEDICAL TRAINEES

U.S. Department of Justice
Immigration and Naturalization Service

Supplementary Statement For
Graduate Medical Trainees

OMB No. 1115-0108
Approval expires 9/85

Affidavit for Exchange Visitor who seeks an extension
of stay in order to complete a program of graduate
medical education and training.

This form must be completed and submitted to the Immigration and Naturalization Service every year for each Foreign Exchange Visitor seeking an extension of stay in order to complete a program of graduate medical education and/or training. The collection of this information is required by Public Law 97-116.

PART 1 To be Completed by Exchange Visitor

I certify that I am in good standing in a program of graduate medical education or training, under the exchange visitor program number indicated below, and that I will return to my country of nationality or last foreign residence upon completion or termination of my participation in the program. I also understand that I must reside in that country for at least two (2) years before I can qualify for an immigrant visa to the United States or for classification as an "H" or "L" nonimmigrant temporary worker.

My name is (please print) _____ ECFMG No: _____
I am in the Exchange Visitor Program No: P-3-4510
My field of study is _____
My country of nationality is _____
My country of last foreign residence is (OTHER THAN THE U.S.A.) _____
I intend to work in the activity or medical specialty of _____
My residential address is _____

I declare and certify under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on (Date) _____ Signature _____

PART 2 To be Completed by Institutional Director of Graduate Medical Education or Training Program

I certify that the graduate medical student or trainee named in Part 1 is in good standing in the Exchange Visitor Program identified and that the information he or she provided is true and correct to the best of my knowledge.

Name of program director (please print) _____

Exact title of program director _____

Name of institution _____

Address of institution _____
Street Name and Number City and State Zip

Executed on (Date) _____ Signature _____

Form I-644 is an attestation of the exchange visitor physician's good standing in the Exchange Visitor Program as of his/her participation in his/her most recent host program. It must, therefore, be completed by the program director or the director of graduate medical education at the current, or most recent (not proposed) host institution.

Guidelines for Fellowship Program Description

One requirement for ECFMG sponsorship in subspecialty training is submission of a detailed program description. ECFMG developed the following as a guide for development of the program description to meet this sponsorship requirement. This outline is modeled after the format described 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 twelve 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.