# Connecticut Conrad 30 / J-1 Visa Waiver Program

## Program Overview

The State of Connecticut is committed to addressing the physician shortage in the state. By use of the Conrad 30 Waiver Program, the State of Connecticut strives to address physician shortage by waiving the two (2)-year home country residency requirement of up to thirty (30) Foreign Medical Graduates and allowing them to continue to practice in areas that are designated as underserved.

The U.S. Department of Health and Human Services designates an underserved areas as either Health Professional Shortage Area (HPSA); Medically Underserved Area (MUA), and Medically Underserved Population (MUP). HPSA's are designations that indicate health care provider shortages in primary care, dental health; or mental health. MUA's are these areas of a geographic location, whereas MUP's are underserved populations.

The underlying objective of these waivers is to recruit physicians into communities where medical services are in short supply. Physicians benefiting from these waivers must provide clinical services to a specific community for at least three years. Although Connecticut makes no distinction between primary care physicians and specialty physicians, definitions for each follow:

*Primary Care Physician Applicant*
Primary care is interpreted to include allopathic and osteopathic physicians who are trained in, and will practice, internal medicine, pediatrics, family practice, obstetrics-gynecology, geriatrics, and psychiatry.

*Specialty Physician Applicant*
DPH will support requests for placement of physicians who are currently enrolled in or have completed a subspecialty or non-primary care fellowship. Should the specialty be one designated by the Commissioner of Public Health, then the application to support this specialty physician must provide descriptive information and data that specifically identify how the specialty physician will address the needs of the community.

This application packet is to be completely filled out and combined with all necessary additional documents in order below:

- ✓ Cover Page
- ✓ Index
- ✓ 3rd Party Barcode
- ✓ J-1 Waiver Application / DS-3035
- ✓ CT DPH Conrad 30 / J-1 Visa Waiver Application Sheet
- ✓ Evidence of Coverage Shortage Form
- ✓ HPSA Search Results
- ✓ Statement of need by employer
- ✓ Recruitment Efforts
- ✓ Agreement to INA Section 214(*l*)
- ✓ Certificate of Eligibility / DS-2019
- ✓ Curriculum Vitae
- ✓ Connecticut Medical License
- ✓ Employment Contract
- ✓ Notice Of Entry Of Appearance As Attorney or Accredited Representative / G-28 (if applicable)
- ✓ "No Objection" Letter from Home Country (if applicable)
- ✓ Monitoring and Reporting Agreement

*Please provide Case Number and Name on the top right corner of every document in the space provided.

## Eligibility Requirements

**Federal**

- The Physician Applicant will agree to begin employment within ninety (90) days of receipt of the waiver.
- The Physician Applicant will commit to three (3) years of full-time employment.
- The Physician Applicant will serve in a federally designated underserved area.

**State of Connecticut**

*Physician Applicant*

- The Physician Applicant holds a current and valid Connecticut physician license at the time of the Department's review of applications.

*Employing Agency*

- A facility located in an area designated by U.S. Department of Health and Human Services (HHS) as a Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or Medically Underserved Population (MUP).
- A facility not located in an area designated by HHS as a HPSA, MUA or MUP must attest that a minimum of thirty percent (30%) of the health care facility's patients reside in a HPSA, MUA or MUP.

**FLEX 10**

The Conrad 30/J-1 Visa Program legislation authorizes up to ten (10) Flex slots to place physicians in practice sites not located in a federal shortage area if documentation is provided to demonstrate that the facility serves patients who reside in one or more federally designated shortage area or meet other unusually high-need criteria determined by DPH. In the event that the total number of applications received is more than the maximum number permitted under federal law, no more than three (3) Flex waiver applications may be forwarded to the director.

## Application Selection Process

The following outlines the application process to the Connecticut Conrad 30 J-1 Visa Waiver Program at the Department of Public Health ("the Department" or "DPH"). Connecticut's participation in the program is voluntary. Submission of a waiver application does not ensure that the Department will sponsor that physician for a waiver. In all instances, the Department reserves the right to sponsor or decline any request for a waiver.

For the Conrad 30 Waiver Cycle 2024 - 2025, the Department will sponsor up to thirty (30) complete applications that meet all federal eligibility requirements and sections 19a-2a-24 through 19a-2a-26 of the Regulations of Connecticut State Agencies.

The Department will accept delivery of paper and e-mailed PDF applications beginning at 8:00 A.M. EDT on October 1, 2024 through October 15, 2024 at 4:30 P.M. EDT. An application is considered complete when two copies of the application, with at least one copy being the original paper application, is received by the deadline via hand delivery, email, or other delivery method. All original applications and copies must be delivered to the following address:

CONRAD 30 WAIVER
Connecticut Department of Public Health
Primary Care Office
410 Capitol Avenue, MS # 11PCO
Hartford, Connecticut 06134-0308

Electronic applications in PDF format are not required but can be sent to DPH-PCO@ct.gov

If the Department receives fewer than thirty (30) complete applications permitted under federal law, the department shall post a notice on its Internet website that it will continue to receive applications until April 1st of the same federal fiscal year, or until the number of applications deemed complete reaches the maximum permitted under federal law, whichever occurs first. Any applications received after October 15th under this section shall be evaluated by the department in the order of their receipt.

## Lottery Process

If the Department receives greater than thirty (30) complete applications in accordance with section 19a-2a-26 of the Regulations of Connecticut State Agencies, all qualifying applications will be entered into a lottery system to randomly select thirty (30) applications for recommendation to the Director. The Department will conduct the lottery at a later date which will be posted on the Department website. The public is welcome to attend the lottery drawing.

The Department will recommend applications to the Director as described in section 19a-2a-26 of the Regulations of Connecticut State Agencies.

***Terms and Abbreviations***

1. **Applicant** – a foreign medical graduate physician or surgeon licensed pursuant to chapter 370 of the Connecticut General Statutes
2. **Application** – an application for waiver of a two-year foreign residence requirement for a foreign medical graduate holding a J-1 visa
3. **Health Professional Shortage Areas (HPSA)** – designations that indicate health care provider shortages in primary care, dental health; or mental health.
4. **International Medical Graduates (IMG)** – a physician who has graduated form a medical school outside of the United States.
5. **Medically Underserved Areas (MUAs)** – a shortage of primary care health services for residents within a geographic area.
6. **Medically Underserved Populations (MUPs)** – specific sub-groups of people living in a defined geographic area with a shortage of primary care health services.

# Checklist

Please attach corresponding files here. Files with a (*) next to them are fillable in this form and do not need to be attached.

Cover Page ..... Attach File

Index ..... Attach File

3rd Party Barcode ..... Attach File

J-1 Waiver Application / DS-3035 ..... Attach File

*CT DPH Conrad 30 / J-1 Visa Waiver Application Sheet .....

*Evidence of Coverage Shortage Form .....

HPSA Search Results ..... Attach File

Statement of need by employer ..... Attach File

Recruitment Efforts ..... Attach File

*Agreement to INA Section 214(*l*) .....

Certificate of Eligibility / DS-2019 ..... Attach File

Curriculum Vitae ..... Attach File

Connecticut Medical License ..... Attach File

Employment Contract ..... Attach File

Any G-28 Forms (if applicable) ..... Attach File

"No Objection" Letter from Home Country (if applicable) .....

*Monitoring and Reporting Agreement .....

Cover Page

**Please place this spacer page in front of each section according to the label at the top of the page.**

# Index

Refer to Index listed above in "Program Overview."

**Please place this spacer page in front of each section according to the label at the top of the page.**

3rd Party Barcode

https://j1visawaiverrecommendation.state.gov/

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# J-1 Waiver Application / DS-3035

https://j1visawaiverrecommendation.state.gov/

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# CT DPH Conrad 30 Waiver / J-1 Visa Application Sheet

**Please place this spacer page in front of each section according to the label at the top of the page.**

Conrad 30 Waiver/J-1 Visa Application Sheet

Case Number # _____
Name_____

**Confidential Information**

This form must be completed and filled electronically.

Primary Care Office-Conrad-30/J1Visa Waiver Program
Connecticut Department of Public Health
410 Capitol Avenue, MS # 11PCO, Hartford, CT 06134-0308

Physician First Name: _____MI: _____ Sex: Male ◯ Female ◯

Physician Last Name: _____ Primary Spoken Language: _____

Date of Birth: _____ Dept. of State Case (DOS) #: _____

Country of Birth: _____ DS-2019 Expiration Date: _____

Physician Preferred Phone #:_____ Physician E-mail address: _____

Primary Care Practice Type: _____ Specialty Practice Type: _____ NPI (optional):_____
(*Do not include Hospitalists)*

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Employer Name: _____

Employer Address: _____City _____State ____Zip_____

Employer Contact Name: _____ Phone: _____

Email of Contact: _____

Practice Site Type: Internal Medicine If other type, please specify/describe_____

Urban ☐ Rural ☐ Non-profit ☐ For profit ☐

Practice Site 1 Name: _____ Medicaid Billing Number: _____

Practice Site 1 Address: _____City_____State_____ Zip_____

County: _____ Census Tract: _____ # of hours to be spent at this site: _____

HPSA #: _____ MUA or MUP # (if applicable): _____ FLEX? Yes

Practice Site 2 Name: _____Medicaid Billing Number: _____

Practice Site 2 Address: _____City_____State _____Zip_____

County: _____ Census Tract: _____ # of hours to be spent at this site: _____

HPSA #: _____ MUA or MUP # (if applicable):_____FLEX? Yes

**Please complete another form for any additional sites.**

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Lawyer Name (write N/A if none): _____Lawyer Email: _____

Law Firm Name: _____

Law Firm Address: _____

Phone: _____ Fax: _____

# Evidence of Coverage Shortage Form

**Please place this spacer page in front of each section according to the label at the top of the page.**

Case Number # _____
Name_____

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

**FORM DPH-1** Evidence of Current Shortage Area Designation

The Chief Administrator (Chief Administrative Officer/President/Administrator) of the health care facility shall complete the information required below and include this form with the application.

Name of Facility: _____ License No.:_____

Address: _____

_____

_____

Facility Census Tract No.: _____ Type of Shortage Area:_____
(i.e. Primary Care or Mental Health)

HPSA ☐ yes ☐ no Service Area Number, including Census Tract Numbers: _____

If population designation, please describe group: _____

MUA ☐ yes ☐ no Service Area Number, including Census Tract Numbers: _____

If population designation, please describe group: _____

MUP ☐ yes ☐ no Service Area Number, including Census Tract Numbers: _____

If population designation, please describe group: _____

Name of Physician Applicant: _____ Specialty: _____

Connecticut License Number: _____

Country of Origin: _____

********** (FOR OFFICE USE ONLY)**********

The Department of Public Health has determined that the facility referenced above is located in an area designated by the United States Department of Health and Human Services as a health professional shortage area.

_____ _____
Signature of Authorized Representative of BCH Date

Comments (Only required if the above IS NOT designated as a shortage area):_____

_____

*Phone: (860) 509-7590*
*Telephone Device for the Deaf (860) 509-7191*
*410 Capitol Avenue – MS #11PCO, Hartford,*
*CT 06134*
*An Equal Opportunity Employer*

# HPSA Search Results

Please visit: https://data.hrsa.gov/tools/shortage-area/by-address

1. Enter the address of the employing facility
2. Print out search results

**Please place this spacer page in front of each section according to the label at the top of the page.**

# Statement of Need by employer

The Statement of need should include the following:

- Description of health care facility and nature of services provided
- Location and Confirmation of shortage designation status (if Flex application, must prove that 30% of patients are from designated shortage areas)
- Proposed responsibilities of J-1 Physician
- Why the J-1 Physician is needed in the facility

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# Recruitment Efforts

This section can include anything that proves that recruitment efforts have failed.
(Advertisements, Job Postings, etc.)

**Please place this spacer page in front of each section according to the label at the top of the page.**

# Agreement to INA Section 214(*l*)

If this is already included in the employment contract, this form is optional.

**Please place this spacer page in front of each section according to the label at the top of the page.**

Case Number # _____
Name _____

# Statement Of Physician Agreement

I, _____, consent to the following:

1) I agree to meet the contractual requirements set forth in section 214(*l*) of the Immigration and Nationality Act.

2) I agree to begin my employment with _____ within 90 days of receiving my J-1 waiver.

3) I agree to work for at least 3 years on a full-time basis for at least forty (40) hours per week serving the medically underserved population as a _____ for
Specialty
_____, at the following address(es):
Employer
Site 1: _____
Site 2: _____
Site 3: _____
**Please complete another form for additional sites.**

4) I agree to practice medicine in accordance with INA Section 214(*l*), paragraph (2) for a total of not less than three (3) years for the geographic area or areas, which are designated by the Secretary of Health and Human Services as having a shortage of healthcare professionals.

5) I,_____ hereby declare and certify, under penalty of the provisions of 18 USC.1001, that: (1) I have sought or obtained the cooperation of _____; and (2) I do not have a pending request nor will I submit another request to any U.S. Government department or agency or its equivalent, to act on my behalf in any matter relating to a waiver of my two-year home residence requirement.

Applicant Signature _____

Date _____

*********FOR NOTARY PUBLIC OR COMMISSIONER OF THE SUPERIOR COURT**********

Sworn to before me on this ___ day of _____, 20__, the above referenced individual personally appeared before me, who being duly sworn says that he/she is the person referred to in the foregoing application, the photograph attached hereto is a true picture of self and that the statements made herein or on any document attached hereto are true in every respect.

My Commission Expires: _____

Signature: _____
Notary Public or Commissioner of the Superior Court

# Certificate of Eligibility / DS-2019

Please include copy of current DS-2019 form.

**Please place this spacer page in front of each section according to the label at the top of the page.**

# Curriculum Vitae

**Please place this spacer page in front of each section according to the label at the top of the page.**

# Connecticut Medical License

Provide a photocopy of Connecticut Medical License or electronic verification of licensure status from the Department of Public Health website

**Please place this spacer page in front of each section according to the label at the top of the page.**

# Employment Contract

The employment contract must address the following:

- Physician will agree to work full time, at minimum 40 hours per week, in a specified medical specialty at specified practice locations.
- Physician agrees to commence employment with the health facility or health care organization within ninety (90) days of receiving the waiver as long as H-1B status is approved and continue for a minimum of three (3) years.
- Physician agrees to practice on a full-time basis providing patient care in Health Professional Shortage Areas and Medically Underserved Areas/Populations (or to patients residing in these locations) and to focusm edical services on the indigent community.
- Physician agrees to the requirements set forth in Section 214(*l*) of the Immigration and Nationality Act.

**Please place this spacer page in front of each section according to the label at the top of the page.**

Any G-28 Forms (if applicable)

**Please place this spacer page in front of each section according to the label at the top of the page.**

# "No Objection" Letter from Home Country (if applicable)

A "No Objection" letter is only required if the applicants home country is funding the exchange program.

**Please place this spacer page in front of each section according to the label at the top of the page.**

# Monitoring and Reporting Agreement

In an effort to evaluate the Conrad 30 / J-1 Visa Waiver Program, monitoring and reporting of the applicant will be required.

**Please place this spacer page in front of each section according to the label at the top of the page.**

# Monitoring and Reporting for Evaluation Agreement

The Connecticut Conrad 30 / J-1 Visa Waiver Program will record and monitor accepted J-1 physicians practicing in shortage designation areas in order to evaluate this program and use this data for further modification of the program.

J-1 physicians and employers must fill out and return the Verification Form within 30 days of the start of employment.

J-1 physicians and employers must also fill out and return the Monitoring Report Form at the end of each contracted year throughout the entie three (3) year employment commitment.

By signing this form, you agree to complete these requests throughout the program.

_____ _____

Physician Signature Date

_____ _____

Employer Signature Date