Department of Health

2026 State 30 J-1 Visa Waiver Program Application Packet

Please read the instructions below in applying to the Ohio State 30 J-1 Visa Waiver Program. Applications that are complete and submitted in the order prescribed will be reviewed before those that do not follow submission guidelines.

I. Notice of Intent to Apply:

Please complete the form and submit as soon as possible. Form can be found on program webpage.

II. To begin the application process to the Ohio State 30 J-1 Visa Waiver Program:

In order to apply for a J-1 visa waiver, the J-1 physician must first file for a case number with the U.S. Department of State (DOS). Filing for a case number with DOS requires completing and submitting the online data sheet (DS – 3035), along with the DOS processing fee of $120. Please do not submit the processing fee to the Ohio Department of Health (ODH). The processing fee must be submitted directly to DOS. Upon submitting the DS – 3035 online, the J-1 physician's information is immediately downloaded into a barcode and a case number is issued. A copy of this barcode is required for application to the Ohio State 30 J-1 Visa Waiver Program.

III. Submitting an Ohio State 30 J-1 Visa Waiver Application:

1. Mail the application fee and fee form to:
   Ohio Department of Health
   Attn: Revenue Unit
   246 N. High St., 5th floor
   Columbus, OH 43215
2. Scan and email the application, fee check, and fee form to: PCRH@odh.ohio.gov.
   Please ensure that the application does not include live electronic signatures.

Be sure to check all documents for accuracy and consistency before submission. Discrepancies will require clarification, which will result in a delay in processing the application. Please note, no information pertaining to the application status will be provided while the application is in review.

Formatting Requirements:

Please use dividers/cover pages for each section of the application. Include U.S. DOS case number on bottom right of each page.

1. **Non-refundable application fee**. Please make checks payable to Treasurer, State of Ohio, in the amount of $3,571.

2. **Application Fee Form:** This form must be completed and submitted per instructions detailed in section III above.

3. **2026 State 30 J-1 Visa Waiver Program Priorities Form.** This form outlines program priorities and provides applicants with a clear understanding of their selected priority category.

4. **2026 ODH State 30 J-1 Visa Waiver Program Application.** This fillable form must be typed.

5. **Sliding fee scale (SFS)** based on 200% of the current federal poverty level, for the sponsoring organization and practice site, if different. The current federal poverty guidelines are available at https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines. Also include a copy of the policy that explains the SFS implementation and the patient application for SFS services. **Hospital SFS information (both the SFS itself and the related policy) must clearly indicate that the SFS applies to physician services.** For more information about SFS, see example in the appendix of the National Health Service Corps site reference guide at https://nhsc.hrsa.gov/sites/default/files/nhsc/nhsc-sites/nhsc-site-reference-guide.pdf

6. **New practice site plan to achieve minimum SFS and Medicaid requirements** (if applicable).
Note, new practice sites are allowable only for primary care or psychiatry in health professional shortage areas (HPSAs) as described in program priority category 1.A.

7. **Integrated Behavioral Health Care Supplement Form** (2026 program priority category 1.A.): This form is to be completed for primary care physicians seeking placement in mental health HPSAs and psychiatrists seeking placement in primary care HPSAs.

8. **Non-Primary Care Supplement Form** (2026 program priority category 2):
This form is to be completed by the sponsoring organization if the J-1 candidate is a non-primary care physician as described in program priority category 2. Applications for primary care physicians who will be practicing in an inpatient setting, including hospitalists or emergency medicine, are considered non-primary care applications and must complete this form. For assistance in identifying the following sites in the practice site's service area with regards to #2 on the form: federally qualified health centers (https://www.ohiochc.org/page/findchc), certified rural health clinics (https://publicapps.odh.ohio.gov/eid/Provider_Search.aspx), free clinics (https://www.charitablehealthcarenetwork.org/), or community mental health agencies (https://findtreatment.gov/).

9. **Non-Primary Care Supplement for Public, Children's and Critical Access Hospitals on 2026 List Form** (2026 program priority category 2.B.):
Public, children's, and critical access hospitals on the 2026 list may apply for a "regular" slot for a non-primary care placement located in the medically underserved area/population (MUA/P) on the 2026 list by providing a plan for outreach to the primary care and/or behavioral health safety net providers in the service area to assure that they are aware of the physician's availability to Medicaid and uninsured patients in the community. The plan should specify collaborative efforts with the federally qualified health centers, certified rural health clinics, free clinics, community mental health agencies, or other safety net providers in the practice site's service area. For assistance in identifying these types of sites, please refer to the links in item #8 of the application packet instructions (above). **If the information provided does not clearly satisfy the requirements of this form, application will be considered for a "flex" slot in program priority category 2.C.**

10. **Flex Slot Supplement Form** (2026 program priority categories 1.C. and 2.C.):
This form is to be completed if the proposed practice site(s) is/are located outside of a HPSA or outside of an MUA/P on the 2026 list. **Note, ODH has the sole discretion to limit the number of waiver recommendations for sponsors who submit multiple applications and for those who currently sponsor physicians serving in the Ohio J-1 Visa Waiver Program.**

11. **Signed Public Notice Regarding Charges for Health Care Services form,** which must be prominently posted at each approved practice site. **Please submit a form for each proposed site with the appropriate signatures from the sponsoring organization official and practice site official.**

12. **Evidence of J-1 physician applicant's Ohio medical license, or application for licensure with the State Medical Board of Ohio**. It is the responsibility of the applicant to assure that all materials for the physician licensure have been submitted to the State Medical Board of Ohio, and to forward notice of licensure upon receipt from the board.

    Note: ODH will not finalize a waiver recommendation until a license is issued or until confirmation is received from the medical board that the only outstanding documentation required to issue a license is completion of the final year of the physician's training. If sponsor is an individual physician, please attach evidence of current, unrestricted Ohio medical license and provide assurance that sponsoring physician does not have a J-1 visa waiver obligation.

13. **Signed ODH State 30 J-1 Physician Applicant Agreement**, which includes agreement to complete a Verification of Employment Form and semi-annual patient activity reports.

14. **Copy of Data Sheet DS-3035 and receipt of paid processing fee** (see section II above). Please be sure to include the following in the application packet. **Note, for State 30 applications, please ensure the request type is State Health Agency Request.**

    - Waiver Review Division Barcode Page.
    - Third Party Barcode Page.
    - J-1 Visa Waiver Recommendation Application.
    - Supplementary Applicant Information Page.
    - Statement of Reason.

15. **Employment agreement, which must include:**

    - ☐ The complete address(es) of the practice location(s).
    - ☐ A full-time, 40-hour work week in direct clinical care for three years. (On-call, travel time, continuing medical education, administrative duties, research, and teaching are not counted in the required 40-hour work week.)
    - ☐ A statement documenting that the J-1 physician candidate agrees to begin work within 90 days of receipt of the J-1 waiver and the H1-B visa.
    - ☐ A competitive salary for the area. Specify salary will not fall below prevailing wage during three years.
    - ☐ The statement: "Any change or amendment to the employment contract must adhere to Ohio Department of Health J-1 Visa Waiver requirements."
    - ☐ The statement: "Changing or adding of practice site(s) cannot be done without prior approval from ODH and USCIS."
    - ☐ Signature and date by both employer and physician.

    Please note, the employment agreement cannot include:

    - ☐ A non-compete clause.
    - ☐ Termination without cause or by mutual agreement until the statutorily required three years have expired.
    - ☐ Physician's employment start date cannot be prior to the receipt of the physician's J-1 waiver and H-1B visa. Physician can only begin term after receipt (within 90 days) of the J-1 waiver approval and H-1B visa.
    - ☐ In addition, only one employment agreement is permitted between the sponsor and the J-1 physician during the physician's three-year obligation. Contracts that may be in place for physicians on O-1 visas prior to receipt of J-1 visa waiver approval must be terminated before the physician's J-1 visa waiver obligation start date.

16. **Signed Agreement to Contractual Requirements: Section 214(l) of the Immigration and Nationality Act form.**

17. **Signed Exchange Visitor Attestation form**.

18. **All IAP-66/DS-2019 forms:** Please provide legible copies in chronological order with no time gaps.

19. **Sponsoring organization's letter to Dr. Bruce Vanderhoff, Director of Health**, which must:
    - ☐ List the sponsoring organization, practice site(s) (if different), and name and specialty of J-1 physician applicant.
    - ☐ Define the service area for the sponsoring organization and practice site, if different.
    - ☐ Provide site-specific staffing information, including total number of positions by specialty and number of vacancies.
    - ☐ Describe how this request will address unmet need in the service area specifically for the medical specialty of the J-1 physician applicant.
    - ☐ Document that efforts to recruit a U.S. citizen physician for the same specialty and site have been conducted over the past 12 months and have been unsuccessful. A summary description is requested. Do not submit copies of ads, emails, recruitment firm contracts, etc.

20. **Evidence of shortage designation status** for placements in HPSAs and MUA/Ps on the 2026 list only. Please verify HPSA or MUA/P status at https://data.hrsa.gov/tools/shortage-area/by-address and submit a copy of the verification from the HRSA website.

21. **Curriculum vitae of J-1 physician.**

22. **Form G-28 for representative of sponsoring organization** (if applicable): If Form G-28 is not applicable, please submit a signed and dated letter of representation that indicates the representative of the sponsoring organization.

23. **Copies of most recent I-94 DHS printout.**

24. **Checklist indicating that application has been thoroughly reviewed for accuracy and consistency.** For State 30 applications, please complete only the 2026 State 30 J-1 Visa Waiver Application Checklist.

IV. Recommendations by the Director of Health:

Applications that receive a recommendation for approval by the Director of Health will be forwarded to the U.S. Department of State (DOS) for review, along with the cover letter from ODH. A copy of this cover letter will be sent to the sponsor-identified contact person for reference. Once the application has been approved by DOS, it is forwarded to U.S. Citizenship and Immigration Services (USCIS). As the waiver-granting authority, USCIS will then issue the H-1B work visa for an approved application.

Applicants that are not recommended for approval will be sent formal notice from ODH. Applications are valid for the program year (federal fiscal year) only. For consideration in the following program year, a new application and accompanying fee must be submitted.

Department of Health

2026 State 30 J-1 Visa Waiver Program Application Fee Form

This form must be complete and attached to the application fee check to be mailed to the ODH Revenue Unit. Please also include a copy of the completed fee form and fee check with the application packet emailed to PCRH@odh.ohio.gov. For more information on submission instructions, please see section III in the application instructions packet.

I. Sponsor Information:

Sponsoring Organization Name: _____

Contact Person Name: _____

Phone Number: _____

Email Address: _____

II. Physician Information:

Physician Name: _____

Physician Specialty: _____

III. Attorney/Representative Information:

Name: _____

Phone Number: _____

Email Address: _____

IV. Payment Information:

Payer/Customer Name:_____

Check Number:_____

Payment Date:_____

Department of Health

2026 State 30 J-1 Visa Waiver Program Priorities Form

The Ohio J-1 Visa Waiver Program maintains a preference for primary care physicians who will practice outpatient care in safety net sites located in health professional shortage areas (HPSAs) and physicians who will assist in meeting the state's behavioral health workforce needs. Applications will be prioritized in the order listed below and considered in the highest applicable category.

ODH has the sole discretion to limit the number of waiver recommendations for sponsors who submit multiple applications and for those who currently sponsor physicians serving in the Ohio J-1 Visa Waiver Program. Application reviews will also include evaluation of the sponsor's adherence to program requirements for current and past participants.

Please check the appropriate program priority for this application. Choose only one category. Applications for multiple practice sites will be considered only for a "flex" slot if any one of the sites is classified as a "flex" slot.

Category 1: Primary Care and Behavioral Health– This category includes physicians who are completing post-graduate training in the primary care specialties of family practice, general internal medicine, obstetrics/gynecology, general pediatrics, combined internal medicine/pediatrics, adolescent medicine, or geriatrics and will practice in an outpatient setting. It also includes physicians who are completing post-graduate training in behavioral health, including general psychiatry, child/adolescent psychiatry, geriatric psychiatry, addiction psychiatry, or addiction medicine and will practice in an outpatient or inpatient setting. Physicians who have completed post-graduate training in other specialties will not be considered in this category.

- ◯ **A.** Primary care specialties in primary care HPSAs and psychiatry specialties in mental health HPSAs, including state psychiatric hospitals designated as facility HPSAs. Physicians who practice primary care or psychiatry specialties in an integrated care site in *either* primary care *or* mental health HPSAs are also included in this category.

- ◯ **B.** Primary care and psychiatry specialties in medically underserved areas/populations (MUA/Ps) on 2026 lists (Eligible public, children's, and critical access hospitals in MUAs list and eligible MUA/Ps list).

- ◯ **C.** All other primary care and psychiatry placements– "flex" slots (proposed practice site(s) located outside of a HPSA or outside of an MUA/P on the 2026 lists).

<u>Category 2:</u> Non-Primary Care – This category includes all specialties not named in Category 1 and primary care specialties that practice in an inpatient setting (e.g., hospitals, nursing homes).

- ◯ **A.** Non-primary care specialties in primary care HPSAs and psychiatry subspecialties in mental health HPSAs. Note, non-primary care specialties may not use a hospital-affiliated primary care facility HPSA to be considered in this sub-category.

- ◯ **B.** Non-primary care specialties and psychiatry subspecialties in MUA/Ps on 2026 lists (Eligible public, children's, and critical access hospitals in MUAs list and Eligible MUA/Ps list).

- ◯ **C.** All other non-primary care specialties and psychiatry subspecialties placements– "flex" slots (proposed practice site(s) located outside of a HPSA or outside of an MUA/P on the 2026 lists).

_____ _____

Physician Name Sponsor Name

Ohio Department of Health

2026 State 30 J-1 Visa Waiver Program Application

PLEASE TYPE RESPONSES

I. Sponsoring Organization Information

Sponsoring Organization Name:

Address:

City: State: ZIP+4: County:

Contact Person: Title:

Email: Phone:

Type of Practice

- ☐ Federally Qualified Health Center
- ☐ Certified Rural Health Clinic
- ☐ Critical Access Hospital
- ☐ Free Clinic
- ☐ Office-Based Opioid Treatment
- ☐ Opioid Treatment Program
- ☐ Federally Qualified Health Center Look-Alike
- ☐ Community Mental Health Agency
- ☐ State Agency _____
- ☐ Other (specify) _____

Type of Organization

○ For-Profit ○ Non-Profit ○ Public

Number of Years in Operation

_____

II. Physician Information

Name, Last: First: Middle:

Phone:

Address:

Cell:

City: State: ZIP+4:

Email:

Country of Birth: Country of Last Residence:

Date of Birth: ___/___/____

Physician Specialty *(select all that apply)*

- ☐ FP ☐ IM ☐ OB/GYN ☐ PED ☐ Adolescent Medicine ☐ Geriatrics
- ☐ General Psychiatry ☐ Child/Adolescent Psychiatry ☐ Geriatric Psychiatry
- ☐ Addiction Medicine ☐ Addiction Psychiatry ☐ Other: _____

Date Available: ___/___/____

National Provider Identifier (NPI):

Languages Spoken

_____

_____

_____

Race *(select all that apply)*

- ☐ American Indian/Alaskan Native
- ☐ Pacific Islander/Native Hawaiian
- ☐ White ☐ Asian
- ☐ Black or African American
- ☐ Other: _____

Ethnicity *(select only one)*

○ Hispanic or Latino/a
○ Not Hispanic or Latino/a

Education

Medical School: _____ City/Country: _____

Dates of Attendance: ___/___/___ through ___/___/___ Graduation: ___/___/____

Residency Program: _____ City/State: _____

Dates of Attendance: ___/___/___ through ___/___/___ Graduation: ___/___/____

Additional Training: _____ City/State: _____

Dates of Attendance: ___/___/___ through ___/___/___ Completion: ___/___/____

Current Visa Status *(select one)*. **If another type of visa is being pursued, please specify in "Other."**

○ J-1 ○ H-1B ○ O-1 ○ Out of Status (Note, not eligible) ○ Other: _____

Has the physician applied for asylum?

○ Yes ○ No

Credentials

List state(s) of current licensure. If not currently licensed in Ohio, list date of application. _____

Note any licensure restrictions:

III. Practice Site Information *If more than one practice site is proposed, please copy and complete this form for each site.*

Practice Site Name:

Address:

City: State: ZIP+4: County:

Contact Person: Title:

Email: Phone:

Is the proposed practice site located in a health professional shortage area (HPSA) or medically underserved area/population (MUA/P) on the 2026 lists? Yes ◯ No ◯

Is the proposed practice site an integrated care site? Yes ◯ No ◯

Practice sites that provide integrated primary care and behavioral health services may use primary care and mental health HPSAs in determining the patient origin data. Integrated care sites include 1) primary care sites that offer behavioral health services on-site and 2) behavioral health sites that offer primary care services on-site.

Please list name(s) and I.D. number(s) of HPSA(s) and MUA/P(s) on the 2026 lists where practice site is located and/or where patients originate from: _____

Type of Practice

- ☐ Federally Qualified Health Center
- ☐ Certified Rural Health Clinic
- ☐ Critical Access Hospital
- ☐ Free Clinic
- ☐ Office-Based Opioid Treatment
- ☐ Opioid Treatment Program
- ☐ Federally Qualified Health Center Look-Alike
- ☐ Community Mental Health Agency
- ☐ State Agency _____
- ☐ Other (specify) _____

Type of Organization

◯ For-Profit ◯ Non-Profit ◯ Public

Number of Years in Operation

_____

If more than one practice site is proposed, please list the hours per week the physician will see patients at each practice address.

Site Name/Address	Hours
_____	_____/week
_____	_____/week

Does the practice participate in the Ohio Medicaid program?	Yes ◯	No ◯
Does the practice accept new Medicaid patients?	Yes ◯	No ◯
Does the practice accept assignment in the Medicare program?	Yes ◯	No ◯
Does the practice provide services regardless of the patients' ability to pay?	Yes ◯	No ◯
Does the practice use a **current** sliding fee scale for patients with incomes at/ below 200% of the federal poverty guidelines? *Please attach sliding fee scale and policy.*	Yes ◯	No ◯

Practice Site Payer Mix Data: *Provide actual numbers for the most recent 12-month period and specify the time period. For a new primary care or behavioral health practice site located in a HPSA for which 12-month payer mix data is not available, data for a comparable site may be submitted. If using data for a comparable site, please complete the table below and attach a written plan to achieve the minimum percentages at the new site. Please be sure to identify the comparable site in the written plan.*

Time period: _____

Payer	Number of Unduplicated Patients	Percentage of Total Patients	
Medicaid		0.00%	0.00%
Sliding Fee Scale		0.00%	
Medicare		0.00%	*Total percentage for Medicaid and Sliding Fee Scale must be equal to or greater than 30%.*
Private Insurance		0.00%	
No Charge or No Payment by Client		0.00%	
Other (specify) _____		0.00%	
Total	0	0.00%	

IV. Attorney Information *(if applicable)*

Name, Last: First: Middle:

Name of Firm:

Address:

City: State: ZIP+4:

Email: Phone:

V. Sponsor-Identified Representative *Please identify one contact person who will be responsible for all correspondence on this application. The contact person may be an employee of the sponsoring organization, its legal representative, or the physician applicant.* ***Sponsors submitting multiple applications in a program year must identify the same representative for all applications. Applications that do not follow this requirement will not be reviewed.***

Contact Name: Title:

Name of Organization:

Address:

City: State: ZIP+4:

Email: Phone:

VI. Sponsoring Organization Assurances

My signature below is assurance that this application contains true and correct information and that the site(s) will be in compliance with all Ohio and federal visa waiver requirements as long as any physician is obligated to fulfill his or her visa waiver commitment at the site(s).

Print Name and Title of Sponsoring Organization Official:

_____

Signature of Sponsoring Organization Official:

_____ Date: _____

VII. Physician Assurance

My signature below is assurance that this application contains true and correct information and that I will be in compliance with all Ohio and Federal visa waiver requirements during my J-1 visa waiver commitment.

Print Name of Physician:

_____

Signature of Physician:

_____ Date: _____

Department of Health

2026 State 30 J-1 Visa Waiver Program Integrated Behavioral Healthcare Supplement Form

This form is to be completed for primary care physicians seeking placement in mental health HPSAs (not designated as primary care HPSAs) and psychiatrists seeking placement in primary care HPSAs (not designated as mental health HPSAs).

Please describe the integrated care model at the proposed practice site(s) and how the proposed placement will contribute to the delivery of integrated care.

Department of Health

2026 State 30 J-1 Visa Waiver Program Non-Primary Care (Specialist) Supplement Form

This form is to be completed by the sponsoring organization if the J-1 candidate is a non-primary care (specialist) physician as described in program priority category 2. **Applications for primary care physicians who will be practicing in an inpatient setting, including hospitalists or emergency medicine, are considered non-primary care applications and must complete this form.**

1. On a separate page, please define the service area and its demographics for this placement and explain how this physician will fill an unmet need for the specialty within this service area, the impact of this specialty not being adequately available to the service area, closest location where the specialty is available and evidence that the specialty would be viable in the service area. Include the recommended population-to-physician ratio for the specialty from recognized professional association sources in comparison to the current ratio for the service area. Also include other factors that impact patient access to care, e.g., patient travel time or appointment wait time. Please do not submit copies of journal articles, although citations are encouraged.

2. Two letters documenting collaboration with federally qualified health centers, certified rural health clinics, free clinics, or community mental health agencies in the practice site's service area must be attached. For assistance in identifying these types of sites, please refer to the links in item #8 of the application packet instructions. If these types of sites do not operate in the practice site's service area, letters from primary care practices in the service area that serve patients without regard to their ability to pay and are not part of the sponsoring organization may be utilized to fulfill this requirement.

Letter of Collaboration #1:

_____
Name of Site

Type of Site (*select one*):

- ☐ Federally Qualified Health Center
- ☐ Certified Rural Health Clinic
- ☐ Free Clinic
- ☐ Community Mental Health Agency
- ☐ Other (*if above are not in site's service area*):_____

Letter of Collaboration #2:

_____
Name of Site

Type of Site (*select one*):

- ☐ Federally Qualified Health Center
- ☐ Certified Rural Health Clinic
- ☐ Free Clinic
- ☐ Community Mental Health Agency
- ☐ Other (*if above are not in site's service area*):_____

Department of Health

2026 State 30 J-1 Visa Waiver Program Non-Primary Care Supplement for Public, Children's and Critical Access Hospitals on 2026 List Form

Public, children's, and critical access hospitals on the 2026 list may apply for a "regular" slot for a non-primary care placement located in the medically underserved area/population on the list by providing a plan for outreach to the primary care and/or behavioral health safety net providers in the service area to assure that they are aware of the physician's availability to Medicaid and uninsured patients in the community. The plan should specify collaborative efforts with the federally qualified health centers, certified rural health clinics, free clinics, community mental health agencies, or other safety net providers in the practice site's service area. For assistance in identifying these types of sites, please refer to the links in item #8 of the application packet instructions. A separate page may be used for additional space. **If the information provided does not clearly satisfy the requirements of this form, application will be considered for a "flex" slot in program.**

Department of Health

2026 State 30 J-1 Visa Waiver Program Flex Slot Supplement Form

This form is to be completed by the sponsoring organization if the proposed practice site(s) is/are located outside of a health professional shortage area (HPSA) or a medically underserved area/population (MUA/P) on the 2026 list. Specifically, sites applying for primary care and other specialty/sub-specialty positions must complete this form if the practice site(s) is/are located outside of a primary care HPSA or an eligible MUA/P. **Note, ODH has the sole discretion to limit the number of waiver recommendations for sponsors who submit multiple applications and for those who currently sponsor physicians serving in the Ohio J-1 Visa Waiver Program.**

1. Is this facility operated by a state agency? ◯ Yes ◯ No

If yes, please check the agency below and stop (state agencies are deemed to meet program criteria).

◯ Ohio Department of Mental Health and Addiction Services
◯ Ohio Department of Rehabilitation and Correction
◯ Ohio Department of Youth Services
◯ Other _____

If no, please continue to question #2.

2. Has this site been in operation for at least one year at time of application? ◯ Yes ◯ No

If yes, please provide the date that the site became operational (and continue to question #3). _____ mm/dd/yyyy

If no, stop. Please note, eligible sites for flex slots are required to be in operation for at least one year at time of application.

3. Does this site's[1] patient origin data document service to residents of HPSAs, MUA/Ps on the 2026 list and/or Governor's certified shortage areas? ◯ Yes ◯ No

If yes, check which criteria are met.

◯ A minimum of 30% of the site's patients (in the most recent 12-month period) have originated from one or more HPSAs, MUA/Ps on the 2026 list, and/or Governor's certified shortage areas.

◯ A minimum of 20% of the site's patients (in the most recent 12-month period) have originated from one or more HPSAs, MUA/Ps on the 2026 list, and/or Governor's certified shortage areas and there are no geographic, socio-economic, or cultural barriers for these patients in accessing care at this site.

If no, stop. Please note, sites eligible for flex slots are required to meet one of the above.

_____
Name of Practice Site

_____ _____ _____
Signature of Site Official *Date* *Printed Name and Title of Site Official*

_____ _____ _____
Signature of Sponsoring Organization Official *Date* *Printed Name and Title of Sponsoring Organization Official*

[1] *Practice sites that provide integrated primary care and behavioral health services may use primary care and mental health HPSAs in determining the patient origin data. Integrated care sites include 1) primary care sites that offer behavioral health services on-site and 2) behavioral health sites that offer primary care services on-site.*

Department of Health

2026 State 30 J-1 Visa Waiver Program Public Notice Regarding Charges for Healthcare Services

This practice has adopted the following policies, which apply to all physicians at this site.

- We will charge persons receiving healthcare services at no more than the usual and customary rate prevailing in this area. Health services will be provided at no charge, or at a reduced charge, to persons unable to pay for services according to a posted sliding fee scale.
- We will charge for services to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges.
- We will not discriminate against any person receiving health services because of his/her inability to pay for services, or because payment for the health services will be made under the Medicare or the Medicaid programs.
- We will accept assignment for all services for which payment may be made under the Medicare program. We have entered into an appropriate agreement with the Ohio Department of Medicaid and will provide services to Medicaid-covered individuals.

_____

Name of Sponsoring Organization

_____ _____

Signature of Sponsoring Organization Official *Date*

_____

Printed Name and Title of Sponsoring Organization Official

_____

Name of Site

_____ _____

Signature of Site Official *Date*

_____

Printed Name and Title of Site Official

***Please obtain a signature from each appropriate site official and sponsoring organization official; signatures by two different officials are required.**

***This notice is to be posted in a prominent location in the patient waiting area of each site that participates in the Ohio State 30 J-1 Visa Waiver Program. Photos of the posted signage may be required during the term of service of participating physicians.**

Department of Health

2026 State 30 J-1 Visa Waiver Program
Physician Applicant Agreement

I, _____ , M.D., being duly sworn, hereby request the Ohio State Health Officer, acting in his/her capacity as Director of ODH, to review my application for the purpose of recommending waiver of the foreign residency requirement set forth in my J-1 Visa, pursuant to the terms and conditions as follows:

I understand and acknowledge that the submission of a complete application to ODH does not ensure a favorable waiver recommendation. In the event a decision is made not to grant my request, I hold harmless ODH, the Director, and any and all ODH employees, agents, and assigns from any action or lack of action made in connection with this request.

I further understand and acknowledge that the entire basis for the consideration of my request is ODH's voluntary policy and desire to improve the availability of primary medical care, mental health, and sub- specialty care in regions designated as underserved in Ohio.

I expressly understand that this waiver of my foreign residence requirement must ultimately be approved by the U.S. Citizenship and Immigration Services (USCIS). **I agree to provide ODH a completed Verification of Employment Form within 30 days of my waiver obligation employment start date.**

I understand that any recommendation made by ODH on my behalf is specific to the site(s) included in the letter of recommendation from ODH to the U.S. Department of State. Any change in site location must be pre-approved by ODH and USCIS.

I understand and acknowledge that if I willfully fail to comply with the terms of this agreement, ODH will notify USCIS and recommend deportation proceedings be instituted against me. Additionally, any and all other measures available to ODH will be taken in the event of my non-compliance. **Furthermore, I agree to submit semi-annual patient activity reports to ODH on the form supplied by ODH.**

I declare under the penalties of perjury that the foregoing is true and correct.

_____ _____

Signature *Date*

Subscribed and sworn to before me
This _____ day of _____, 20 ___ .
Notary Public

Department of Health

2026 State 30 J-1 Visa Waiver Program Section 214(l) of Immigration and Nationality Act

This is to certify that I, _____, M.D.,
(*print or type name here*)
agree to comply with the contractual requirements set forth in Section 214(l) of the Immigration and Nationality Act, as stated below:

a) The alien demonstrates a bona fide offer of "full-time" (40 hours) employment at a health facility and agrees to begin employment at such facility within 90 days of receiving such waiver and agrees to continue to work in accordance with paragraph (2) at the health facility in which the alien is employed for a total of not less than three years (unless the Attorney General determines that extenuating circumstances exists, such as the closure of the facility or hardship to the alien, which would justify a lesser period of employment at such health facility, in which case the alien must demonstrate another bona fide offer of employment at a health facility for the remainder of such three-year period).

and

b) The alien agrees to practice medicine in accordance with paragraph (2) for a total of not less than three years only in the geographic area or areas that are designated by the Secretary of Health and Human Services as having a shortage of healthcare professionals, or in a health facility that serves patients who reside in one or more geographic areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals.

_____ _____
Signature *Date*

Subscribed and sworn to before me
This _____ day of _____ , 20___ .
Notary Public

Department of Health

2026 State 30 J-1 Visa Waiver Program Exchange Visitor Attestation

I, _____, M.D., hereby declare and certify, under penalty of the
(print or type name here)

provisions of 18 U.S.C. 1001, that: (1) I have sought or obtained the cooperation of the **Ohio Department of Health** for the purpose of submitting an IGA request on my behalf under the Conrad 30 Program to obtain a waiver of the two-year home-country physical presence requirement; and (2) I do not now have pending 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.

_____ _____

Signature *Date*

Subscribed and sworn to before me
This_____ day of_____ , 20 ___ .
Notary Public

Department of Health

2026 State 30 J-1 Visa Waiver Program Application Checklist

Please place documents in the following order and include the U.S. Department of State case number on the bottom right of each page. Applications that are complete and submitted in the order prescribed will be reviewed before those that do not follow submission guidelines.

	1. Application fee (made out to Treasurer, State of Ohio): $3,571.
	2. Application Fee Form.
	3. U.S. DOS case number included on the bottom right of each page.
	4. 2026 State 30 J-1 Visa Waiver Program Priorities Form.
	5. Ohio Department of Health State 30 J-1 Visa Waiver Application.
	6. Sliding fee scale (SFS) based on 200% of the current federal poverty level, for the sponsoring organization and practice site, if different. Also include a copy of the policy that explains the SFS implementation and patient application for SFS services.
	7. New practice site plan to achieve minimum SFS and Medicaid requirements *(if applicable)*.
	8. Integrated Behavioral Health Care Supplement Form *(if applicable)*.
	9. Non-Primary Care (Specialist) Supplement Form *(if applicable)*.
	10. Non-Primary Care Supplement for Eligible Public, Children's and Critical Access Hospitals on 2026 List Form *(if applicable)*.
	11. Flex Slot Supplement Form *(if applicable)*.
	12. Signed Public Notice Regarding Charges for Health Care Services form *(one for each proposed site)*.
	13. Evidence of J-1 physician applicant's Ohio medical license, or application for licensure with the State Medical Board of Ohio.
	14. Signed Ohio Department of Health State 30 J-1 Physician Applicant Agreement.
	15. Copy of Data Sheet DS-3035 and receipt of paid processing fee (**please ensure the request type is State Health Agency Request**): ○ Waiver Review Division Barcode Page. ○ Third Party Barcode Page. ○ J-1 Visa Waiver Recommendation Application. ○ Supplementary Applicant Information Page. ○ Statement of Reason.
	16. Employment Agreement, which must include: ○ The complete address(es) of the practice location(s). ○ A full-time, 40-hour work week in direct clinical care for three years. (On-call, travel time, continuing medical education, administrative duties, research, and teaching are not counted in the required 40-hour work week.) ○ A statement documenting that the J-1 physician candidate agrees to begin work within 90 days of receipt of the J-1 waiver and the H1-B visa. ○ A competitive salary for the area. Specify salary will not fall below prevailing wage during three years. ○ The statement: "Any change or amendment to the employment contract must adhere to Ohio Department of Health J-1 Visa Waiver requirements." ○ The statement: "Changing or adding of practice site(s) cannot be done without prior approval from ODH and USCIS." ○ Signature and date by both employer and physician.

	Please note, the employment agreement cannot include: ○ A non-compete clause. ○ Termination without cause or by mutual agreement until the statutorily required three years have expired. ○ Physician's employment start date cannot be prior to the receipt of the physician's J-1 waiver and H-1B visa. Physician can only begin term after receipt (within 90 days) of the J-1 waiver approval and H-1B visa. ○ In addition, only one employment agreement is permitted between the sponsor and the J-1 physician during the physician's three-year obligation. Contracts that may be in place for physicians on O-1 visas prior to receipt of J-1 visa waiver approval must be terminated before the physician's J-1 visa waiver obligation start date.
	17. Signed Agreement to Contractual Requirements: Section 214(I) of the Immigration and Nationality Act form.
	18. Signed Exchange Visitor Attestation form.
	19. All IAP-66/DS-2019 forms (in chronological order with no time gaps).
	20. Letter from sponsoring organization to Director of Health, must include: ○ List the sponsoring organization, practice site (if different) and name and specialty of J-1 physician applicant. ○ Define the service area for the sponsoring organization and practice site, if different. ○ Provide site-specific staffing information, including total number of positions by specialty and number of vacancies. ○ Describe how this request will address unmet need in the service area specifically for the medical specialty of the J-1 physician applicant. ○ Document that efforts to recruit a U.S. citizen physician for the same specialty and site have been conducted over the past 12 months and have been unsuccessful. A summary description is requested. Do not submit copies of ads, emails, recruitment firm contracts, etc.
	21. Evidence of shortage designation status (for HPSA and eligible MUA/P placements only).
	22. Curriculum vitae of J-1 physician.
	23. Form G-28 for representative of sponsoring organization (*if applicable*), or letter of representation.
	24. Copies of most recent I-94 DHS printout.
	25. Checklist indicating that application has been thoroughly reviewed for accuracy and consistency.

* **Please do not include large documents or extraneous information as part of the application. Only sections that are referenced in required application documents are acceptable.**

* **Please ensure that the application does not include live electronic signatures.**