Well-Ahead Louisiana Primary Care Office

Louisiana Conrad 30/J-1 Visa Waiver Program

# Application Packet Checklist

Physician’s Name: Click or tap here to enter text.

US DOS Case #: Click or tap here to enter text.

Attached to top of application packet

☐ i. Completed Site Information Form

☐ ii. Completed Application Packet Checklist

Louisiana Conrad 30/J-1 Visa Waiver Program Support Request Application Packet:

☐ 1. Form DS-3035 and Third Party Bar Code Page

☐ 2. Cover letter (letter of support from state of Louisiana)—NOT provided by applicant

☐ 3. Copy of dated, signed employment contract

☐ 4. Documentation of ☐ HPSA designation ☐ FLEX (Non-HPSA) status (check which is provided)

If FLEX, you must include the FLEX (Non-HPSA) Support Request Form

☐ 5. Letter of need from practice site

☐ 6. Signed Physician Statement

☐ 7. Curriculum Vitae

Appendix to Louisiana Conrad 30/J-1 Visa Waiver Program Support Request Application Packet:

☐ A. Qualifications—see all items/documents listed in the Application Packet Directions document

☐ B. Notarized Physician Attestation

☐ C. IAP-66/DS-2019 forms for each year in J-1 Visa status

☐ D. Form G-28 or letterhead from law firm, if applicable

☐ E. I-94 Entry and Departure Cards and/or Passport documentation

☐ F. Three (3) letters of professional recommendation — NO FORM LETTERS

☐ G. Original signed copy of Criteria for Support by the State of Louisiana

☐ H. Evidence of employer’s regional and national recruitment efforts

☐ I. Three (3) letters of support from the community—NO FORM LETTERS

☐ J. Specialty Dire Need Criteria Form required for specialists

☐ K. Copy of Verification of Employer’s Valid Medicaid ID Number

☐ L. Prevailing Wage Information

☐ M. Documentation of Sliding Fee Scale/Indigent Care Policy (submit policy & posted policy photo)

☐ N. Explanation for Out of Status, if applicable

☐ O. “No Objection” Statement, if applicable

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name (Please Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature Date