FY 2023 **Attachment 3B**

STATE OF MICHIGAN

Waiver Policy Agreement – Employee

I, the undersigned J-1 physician, understand and acknowledge that the review of this request is discretionary and the Michigan Department of Health and Human Services (MDHHS), will be held harmless if, based on any priority criteria, a decision not to make a waiver recommendation is made.

I understand and agree that if a favorable recommendation is made, I will (a) practice medicine (as defined by the signed contract with the employer) for a minimum of 40 hours per week for at least three (3) years; (b) commence practicing within 90 days of issuance of the waiver, (c) accept all patients regardless of method of payment or ability to pay, and (d) if I am dual-specialized and granted a waiver as a primary care physician or psychiatrist, will not practice as a non-primary care physician as any part of my 40-hour, three-year waiver obligation.

I further understand and agree that prior to requesting a waiver from the United States Citizenship and Immigration Services (USCIS) to move to another area prior to the expiration of the statutorily required three (3) years, I will seek approval from the MDHHS.

I understand that my employer is required by the State of Michigan to report my employment status each year of my waiver obligation, including any termination of the employment contractual agreement between employer and myself within the three-year period of Visa Waiver employment, regardless of whether this termination of employment was initiated by the employer or me. I understand this termination will then be reported to the United States Department of State (USDOS) and the USCIS and that I may be, consequently, deported. The MDHHS will consider the approval of my transfer to another Health Professional Shortage Area in Michigan under three conditions: 1) the termination of my employment contract within the three-year period is beyond my control, 2) the termination of my employment by the employer is not due to reasons that jeopardize the proper care of future patients, and 3) I notify the MDHHS of the termination within five working days of my termination.

I understand and acknowledge that if I fail to comply with the terms of this agreement, MDHHS will notify the USDOS and the USCIS that it is withdrawing its support of the J-1 Visa Waiver. Further, I understand and acknowledge that MDHHS may pursue any action authorized by law if I fail to comply with the terms of this agreement.

I declare that the information provided to MDHHS for purposes of determining whether it will act as an Interested Government Agency is true and correct.

_____ _____

Physician's Signature Date

_____ _____

Notary Date