It is difficult to say what has been in the news more often, healthcare or immigration. Certainly both are hot button issues, and each for good reason. As the immigration debate regarding who should be permitted to immigrate to the U.S. intensifies, so, too, does the equally difficult question as to how America will care for an aging population, especially in light of the Obama administration’s healthcare plan. Under this plan, healthcare will be provided to millions of Americans who currently do not have insurance coverage and thus access to healthcare. While increasing access to medical care is certainly to be applauded, the lack of attention as to how these medical services will be rendered and, most importantly, who will render them, is highly problematic. Indeed, anyone who has tried to schedule a doctor’s appointment knows that such appointments often cannot be obtained for months on end due to the lack of medical personnel. In light of this growing patient population and an already acute shortage of many critical health care professionals, including but not limited to physicians, nurses, physical therapists, occupational therapists, speech pathologists and medical technologists to render these much-needed services, the “importation”— or immigration — of qualified health care professionals to address this shortage takes on even greater importance. However, the immigration laws and rules pertaining to immigration for all of the above medical professional categories, like those pertaining to all immigration categories, are complex, require attention to minute detail, and sometimes do not even include a category in which the medical professional “fits”. Moreover, the rules and regulations pertaining to each of these professions are so very different that each needs (and deserves) a full treatise to discuss and explain the differing immigration procedures and nuances. However, given the above and space constraints, this article will limit itself to (1) providing a brief overview of the various nonimmigrant

1 Wendy Castor Hess, Esquire, a founding partner in the Immigration law firm of Goldblum & Hess, has been practicing immigration law for over 30 years. She currently serves as Chair of the Immigration Committee of the Philadelphia Bar Association, as Vice Co-Chair of the Immigration Committee of the Pennsylvania Bar, as Co-Chair of the AILA (American Immigration Lawyers Association) Philadelphia USCIS (U.S. Citizenship and Immigration Services) liaison committee and as President of HIAS Pennsylvania. A former staff Attorney with the U.S. Department of Justice, Board of Immigration Appeals, Wendy is a frequent speaker at national immigration conferences and the author of numerous immigration articles, especially in the medical and employer sanction fields. Her practice focuses on representing corporate employers in the medical, pharmaceutical, IT and university communities. She also serves as counsel to the Mexican Consulate in Philadelphia and as a columnist for Al Dia, the largest Spanish language newspaper in the Philadelphia area. Wendy is listed in Best (Immigration) Lawyers in America and in the International Who’s Who of Corporate Immigration Lawyers.

2 Yuah Jessica Choi, Esquire is currently an Associate with Goldblum & Hess, and handles employment-based nonimmigrant and immigrant cases, as well as family–based cases. She is currently the Vice Chair of AILA’s Philadelphia Chapter, and previously served as the Treasurer, Secretary, New Members Division Chair, Annual CLE Conference Co-Chair, and CLE Liaison. In addition, Jessica has lectured on business immigration topics and has been published extensively in Korean daily newspapers in the Philadelphia area. Furthermore, Jessica has co-authored articles pertaining to business immigration law including, “Foreign Worker-Related Issues to Spot Before Commencing a PERM Case”. Jessica received her J.D. from the William S. Richardson School of Law of the University of Hawaii in 2005, where she was the Editor-in-Chief of the Asian-Pacific Law & Policy Journal, and received her Bachelor of Arts degree from the University of Pennsylvania.

3 Karen M. Pollins, Esquire is an Associate with Goldblum & Hess and focuses her practice on employment-based immigration, primarily representing physicians and researchers in obtaining non-immigrant visas and permanent resident status. For the last three years, Karen has been selected as a Rising Star in Pennsylvania by Super Lawyers. In addition, Karen has co-authored several articles related to immigration options for medical professionals, including the article entitled Alien-Related Issues to Spot Before Commencing a PERM Case in “The David Stanton Manual on Labor Certification, Successful Strategies under PERM” (AILA, Winter 2008). A graduate of American University in Washington, DC with a double major in International Relations and Latin American Studies/Spanish, she received her law degree from the Temple University Beasley School of Law in Philadelphia.

visas used by foreign medical personnel; (2) highlighting issues that should be spotted and identified prior to a medical institution’s decision to pursue Lawful Permanent Resident (“LPR”) status on behalf of foreign medical personnel; and (3) directing the reader to more comprehensive resources to assist in understanding the related immigration laws and processes. Of course, even with the wealth of information that these resources provide, in an area where much of the law is subject to changing interpretations set forth in perplexing agency memoranda rather than in statute or regulations, there is no substitution for working with seasoned immigration counsel who understands that yesterday’s immigration knowledge may very well not be valid today and knows where to turn to search for those very few concrete answers that exist in this very challenging area of law.

WHERE TO BEGIN: ESSENTIAL IMMIGRATION REFERENCES

In addition to the primary statutory and regulatory references contained in 8 USC, 8 CFR, 20 CFR and 22 CFR, the following publications are essential starting places for any attorney who wishes to properly represent foreign medical personnel:

1. The Physician Immigration Book, Editor-in-Chief Robert Aronson (ILW, 2011);
2. Immigration Options for Nurses and Allied Health Care Professionals, Second Edition, Editor-in-Chief James David Acoba (AILA, 2009);
3. Immigration Options for Physicians, Third Edition, Editor-in-Chief Margaret A. Castillaz (AILA, 2009);
4. The David Stanton Manual on Labor Certification - Successful Strategies for Practice Under PERM, Editors- in-Chief Susan J. Cohen and Jane W. Goldblum (AILA, 2008-09); and

With the exception of the first reference, the above publications are available through the American Immigration Lawyers Association (“AILA”) and can be ordered by contacting AILA directly at www.ailapubs.org. It is important to note that many of the articles and memoranda referred to in this article are difficult to access as they come from sources not readily available to the public (or at least without substantial digging) and thus the above-referenced publications serve as “horn books” for any healthcare lawyer who wishes to wade into the murky waters of immigration law.

ESSENTIAL IMMIGRATION BASICS

The U.S. Immigration law divides individuals into two categories: Nonimmigrants and Immigrants. Nonimmigrants are individuals who enter the U.S. for a “temporary” purpose for a “temporary” period of time. The word “temporary”, however, is rather elusive and not always readily defined or understood. Depending on the purpose, nature, and length of stay, a variety of nonimmigrant visas are available to each individual. The nonimmigrant visas most commonly used by foreign medical personnel include the following:

- **H-1B (“Specialty”/Professional Worker):** This visa is available to individuals who will be employed in a “specialty occupation” requiring at least a U.S. Baccalaureate Degree (or equivalent), and who hold a degree in a field that is related to the intended position.5

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5 8 CFR § 214.2(h).
• **H-1B (Free Trade Agreement):** This visa is available to citizens of Singapore or Chile who will be employed in a “specialty occupation” requiring at least a U.S. Baccalaureate Degree (or equivalent), and who hold a degree in a field that is related to the intended position.6

• **E-3 (Free Trade Worker):** This visa is available to Australian citizens who will be employed in a “specialty occupation” requiring at least a U.S. Baccalaureate Degree (or equivalent), and who hold a degree in a field that is related to the intended position.7

• **F-1 (Students):** This visa is available to individuals who will be pursuing a course of study in the U.S. Individuals who are currently in the U.S. in F-1 status may obtain employment authorization in order to work in a position that is related to their field of study.8

• **J-1 (Trainee/Exchange Visitor):** This visa is available to individuals who will be participating in exchange visitor programs as J-1 Trainees9 or J-1 Interns10. In the medical field, many individuals enter the U.S. in such status in order to receive graduate medical education or training.11 Of great importance, with rare exceptions (and as will be discussed in greater detail shortly), they are subject to the dreaded two year foreign residence requirement.12

• **O-1 (Extraordinary Ability Foreign Nationals):** This visa is available to individuals who have extraordinary credentials and demonstrate “sustained national or international acclaim.”13

• **TN (NAFTA):** This “visa” category (a non-visa for Canadian citizens as they are not generally required to hold visas in order to enter the U.S.) is for individuals who are citizens of Mexico or Canada, who will be employed in a position that is listed in Appendix 1603.A.3 of NAFTA, and who meet the corresponding requirements.14

In addition to the above listed nonimmigrant visas/categories, foreign medical personnel may also enter the U.S. and hold temporary employment authorization as spouses of those currently in the U.S in

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6 H-1B Free Trade Agreement (“H-1B FTA”) was created pursuant to the U.S.-Singapore Free Trade Agreement and the U.S.-Chile Free Trade Agreement, both of which took effect on January 1, 2004.
7 INA § 101(a)(15)(E)(iii). The E-3 visa was created pursuant to the U.S-Australia Free Trade Agreement.
8 8 CFR § 214.2(f). F-1 students may obtain employment authorization after the completion of the course of study or during the course of their study as long as they have been enrolled in lawful student status on a full-time basis for at least one full academic year, and have not used twelve months of more of full-time curricular practical training.
9 J-1 trainees are individuals who have completed a degree or professional certificate from a foreign post-secondary academic institution and possesses at least one year of prior related work experience outside of the U.S. or 5 years of qualifying experience who will be in the U.S. to participate in a program to gain exposure to U.S. culture and to receive training and exposure to U.S. business practices in their chosen field.
10 J-1 interns are individuals who are currently enrolled in a post-secondary academic institution outside of the U.S., preferably studying in a related field, or have graduated from such an institution no more than 12 months prior to the start date of the program in the U.S. who will be in the U.S. to participate in a program to gain exposure to U.S. culture and to receive training and exposure to U.S. business practices in their chosen field.
11 8 CFR § 214.2(j)(4).
12 INA §§212(e), 214(l), and 248, 8 USC §§1182(e), 1184 (l), and 1258; 22 CFR §41.63.
13 8 CFR § 214.2(o).
14 INA § 214(c). Most professions listed in Appendix 1603.A.3 of the North American Free Trade Agree (NAFTA) require that the individual hold a corresponding baccalaureate or licenciatura degree. However, individuals applying for admission to the U.S. to work in professions such as Management Consultant may qualify for the TN visa without a degree if they possess the specific alternate requirement listed in the Appendix. For example, an individual applying to admission to the U.S. to work as a Management Consultant may qualify for a TN visa if they possess “equivalent professional experience as established by statement” or have “professional credential attesting to five years of experience as a management consultant, or five years of experience in a field of specialty related to the consulting agreement.”
nonimmigrant visa categories such as that of E-1 Treaty Traders,15 E-2 Treaty Investors,16 or L-1 Intra-Company Transferees.17

Foreign national sometimes do exactly that which the term “nonimmigrant” implies: they enter the U.S. for a specific purpose (such as graduate medical training), realize that purpose and then leave the U.S., returning to their home country or elsewhere. Oftentimes, however, nonimmigrants, when statutorily permitted, choose to seek to remain permanently in the U.S. and pursue “lawful permanent resident status”, commonly referred to as a “green card”. Depending upon the foreign national’s level of education and skills and the need for a U.S. employer to utilize such skills/education, that “nonimmigrant” foreign national may be “sponsored”, either through the U.S. employer, or, in some cases, “self-sponsored”18 for Lawful Permanent Resident status. While such sponsorship process is ongoing, the foreign national must consistently maintain lawful presence in the U.S.,19 most typically by retaining lawful, nonimmigrant status in H-1B or O-1 status, until the full sponsorship process, known as “Adjustment of Status”20 is completed. As will be discussed shortly, in some of the categories of foreign medical personnel listed below, this is highly problematic, given the limited amount of time the immigration laws permit them holders of these visa categories to remain in their nonimmigrant status. For others, such as the majority of nurses, the lack of a true nonimmigrant visa classification makes it extremely difficult for them to remain in the U.S. in nonimmigrant status while awaiting receipt of Lawful Permanent Resident status and often forces them to leave the U.S. during the elongated process. When this occurs, hospitals and medical institutions are often “blindsided” and left with critical nursing staff shortages.

**PHYSICIANS**

Both the American Medical Association (“AMA”) and the Association of American Medical Colleges (“AAMC”) have acknowledged the current pressing need for physicians and the anticipated worsening

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15 8 CFR § 214.2(e). A citizen of a country with which the U.S. maintains a treaty of commerce and navigation who is coming to the U.S. to carry on substantial trade, including trade in services or technology, principally between the U.S. and the treaty country, may obtain an E-1 visa. Subsequent to entry into the U.S. as a derivative spouse of the E-1 Treaty Trader, the E-1 Treaty Trader spouse may apply for employment authorization through an application process with the U.S. Citizenship & Immigration Service.

16 8 CFR § 214.2(e). A citizen of a country with which the U.S. maintains a treaty of commerce and navigation who is coming to the U.S. to develop and direct the operations of an enterprise in which the national has invested, or is in the process of investing a substantial amount of capital may obtain an E-2 visa. Much like the E-1 visa, subsequent to entry into the U.S. as a derivative spouse of the E-2 Treaty Investor, the E-2 Treaty Investor spouse may apply for employment authorization through an application process with the U.S. Citizenship & Immigration Service.

17 8 CFR § 214.2(l). The L-1 visa is available to individuals who are being transferred between entities that share a qualifying relationship (the two entities must have a parent/subsidiary, branch, or affiliate relationship and the entities must have at least 50% common ownership) and have been employed by the qualifying foreign entity for at least one year in the last three years in a position that is managerial or executive in nature or requires specialized knowledge of the company’s products, policies, and procedures, and will be employed by the U.S. entity in a position that is managerial or executive in nature or requires specialized knowledge of the company’s products, policies, and procedures. Spouses of individuals in L-1 status may enter the U.S. in derivative L-2 visa status, and subsequently apply for employment authorization.

18 Unlike other employment-based petitions, foreign nationals who meet the requirements of an Alien with Extraordinary Ability [pursuant to 8 CFR §204.5(h)] or an Alien of Exceptional Ability or Advanced Degree Professional eligible for a National Interest Waiver [pursuant to 8 CFR §204.5(k)(4)(ii)] do not need an employer to sponsor them for Lawful Permanent Resident Status and may “self-sponsor”.

19 INA § 212(a)(9)(B).

20 Foreign nationals in the U.S. in lawful status may pursue Lawful Permanent Resident status by adjusting their status while in the U.S. However, a foreign national may also obtain Lawful Permanent Resident status through consular processing if he/she is not physically present in the U.S.
of this physician shortage in the future. Indeed, Dr. Darrell G. Kirch, President and CEO of the AAMC, has stated:

Our nation currently faces a shortage of physicians expected to worsen as the number of people over age 65 (who use more than twice the health care of younger adults) doubles. Even with significant changes to the health-care delivery system and improved prevention, the United States will face a shortage of more than 125,000 physicians in the next 15 years... In addition, the U.S. Department of Health and Human Services (HHS) estimates that at least 16,000 more primary care physicians are needed today.

The U.S. health work force has been rightly criticized because the percentage of physicians in primary care is lower than in most of the developed nations to which we often compare our health system.

Recognizing such need, it would seem that Congress and the U.S. government agencies involved in granting permission to foreign medical physicians to immigrate to the U.S., namely the U.S. Citizenship and Immigration Service (“USCIS”), the U.S. Department of State (“DOS”) and the U.S. Department of Labor (“DOL”), would facilitate the immigration process. Not so, as will soon be discussed.

Foreign physicians arrive in the U.S. generally in three ways: as nonimmigrant J-1 exchange visitors, as nonimmigrant H-1B specialty workers and as Lawful Permanent Residents (“LPRs” or “green card” holding physicians). Clearly, if a physician arrives with LPR status there is no immigration issue. However, the majority of foreign physicians arrive in either J-1 or H-1B status, each of which presents its own challenges in pursuing LPR status.

Challenges to Immigrating the J-1 Physician

The J-1 nonimmigrant visa category allows individuals to participate in “exchange visitor” programs in the U.S., the purpose of which is to promote educational and cultural exchange between the U.S. and other countries. Most J-1 nonimmigrants are subject to a two year foreign residence requirement, meaning that they must return to their country of nationality or country of last residence for a two year...
period after completing their training in the U.S. before they are eligible to apply for nonimmigrant visas such as an H visa, change status inside the U.S. or apply for “Adjustment of Status” to that of a LPR. 26

Pursuant to the Immigration and Nationality Act (“INA”), the following J-1 nonimmigrants are subject to the two year foreign residence requirement: (1) those whose program in the U.S. was financed by the U.S. government or the government of the individual’s nationality or last residence, (2) those whose country of nationality or last residence requires the specialized knowledge or skills of the program in which the foreign national was engaged, as indicated on the Department of State’s “Skills List”, and (3) those who received graduate medical education or training in the U.S. while in J-1 status. 27 Although most J-1 foreign physicians are subject to the two year home residence requirement, many wish to remain in the U.S. after the completion of their training. These physicians are presented with two options: return to their country of nationality/last residence and physically satisfy their two year foreign residence requirement before seeking another type of nonimmigrant visa or immigrant status in the U.S., or immediately seek a waiver of the J-1 two year foreign residence requirement while in the U.S. in order to avoid returning to their home country/country of last residence for any period of time. 28

The INA provides four ways to apply for a waiver of the two year foreign residence requirement: (1) through the support of a federal interested government agency (“IGA”), (2) through the support of a state Department of Public Health or equivalent state agency via the Conrad 30 Program, (3) by demonstrating that complying with the requirement would impose exceptional hardship on the foreign national’s U.S. Citizen or LPR spouse or child, or (4) by demonstrating that the foreign national would be subject to persecution on account of race, religion or political opinion. 29 Before discussing what each of these options entails, it is important to stress and be aware that J-1 physicians who came to the U.S. to receive graduate medical education or training are precluded from availing themselves of the common avenue for obtaining a waiver of their two year home residence requirement that many of their non-clinical J-1 friends and family members routinely utilize: obtaining a “statement in writing” (known as a “no objection letter”) from the country of the foreign national’s nationality or last residence “that it has no objection to such waiver in the case of such alien.” 30 In fact, many an attorney new to this niche area of law has initially made the mistake of thinking that such diplomatic letter would suffice to waive the home country residence requirement; it does not.

1. Federal Interested Government Agencies: IGAs

A U.S. government agency may request a J-1 waiver for an exchange visitor who is actively and substantially involved in a program or activity sponsored by or of interest to that agency. 31 It must be established that a waiver is in the public interest and that the program or activity would be detrimentally impacted if the foreign national were required to comply with the two year home residence requirement and depart from the U.S. 32 Federal agencies that currently support J-1 waiver requests include but are

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26 INA §§212(e), 214(l), and 248, 8 USC §§1182(e), 1184(l), and 1258; 22 CFR §41.63.
27 INA §212(e).
28 Physicians who satisfy the O-1 nonimmigrant standard for “aliens of extraordinary ability or achievement,” while precluded from changing to H-1B status or adjusting status in the U.S., may apply for an O-1 visa at a U.S. consulate abroad. 8 CFR §248.2(a)(3) and (4). However, at some point in time, if they wish to immigrate to the U.S. on a permanent basis, they must pay the proverbial J-1 piper by either serving their two year foreign residence requirement or obtaining a waiver of the same. See generally Robert S. Whitehall & Lisa E. Claypool, O, Those Extraordinary Physicians, in IMMIGRATION OPTIONS FOR PHYSICIANS 159 (Margaret A. Catillaz ed., AILA 2009).
29 Supra note 27.
30 Id.
31 22 CFR §41.63(c).
32 Id.
not limited to the Appalachian Regional Commission (ARC), the Delta Regional Authority (DRA), the Department of Veteran Affairs (VA) and the Department of Health and Human Services (HHS). Some federal IGA-sponsored J-1 waivers, such as those for physicians engaged in research, do not have a clinical service requirement. Therefore, once such waiver is granted, the foreign national may immediately apply for LPR status. Other agencies, however, require the J-1 physician to provide direct clinical services in an underserved area in H-1B status for three years before he/she can submit an application for LPR status. Although the physician generally may not submit an Application for “Adjustment of Status” until the three year service commitment has been satisfied, during this time, his/her employer may file the first two steps of the permanent residency process, the PERM Application with the DOL and, once certified, the I-140 Immigrant Petition with USCIS, which will be discussed shortly.

Procedure for obtaining an IGA waiver:

a. Applicant submits online J-1 Visa Waiver Recommendation Application (Form DS-3035) to obtain a DOS case number and sends the Application, along with a fee and supporting documents, to the DOS’ Waiver Review Division.
b. Applicant submits J-1 waiver application to the federal U.S. IGA;
c. If support of waiver is granted, the U.S. government agency recommends waiver to DOS’ Waiver Review Division;
d. If support of waiver is granted, DOS recommends waiver to USCIS;
e. If USCIS concurs with DOS, USCIS issues final J-1 waiver approval.

2. State Department of Public Health: The Conrad 30 Waivers

Initially only federal government agencies could serve as vehicles for J-1 physician waivers. However, since 1994, as a result of legislation introduced by Senator Kent Conrad (D-ND), state agencies have been permitted to recommend J-1 waivers on behalf of clinical physicians who agree to provide direct patient care within certain areas designated by the U.S. Department of Health and Human Services (HHS) as being medically underserved. Under the Conrad 30 program, each state is granted 30 J-1

33 For more information on the ARC’s J-1 Visa Waiver Program, visit its website at www.arc.gov/j1visawaiver.
34 For more information on the DRA’s J-1 Visa Waiver Program, visit its website at www.dra.gov/programs/doctors/.
35 For more information on HHS’s J-1 Visa Waiver Program, visit its website at www.globalhealth.gov/exchangevisitorprogram/.
36 For example, the U.S. Department of Health and Human Services (HHS) supports waivers for physicians who are engaged in critical research that would be detrimentally impacted if they had to depart the U.S. Id.
37 INA §214(l).
38 Pursuant to the USCIS Interoffice Memorandum of Mr. William Yates, Deputy Executive Associate Commissioner, dated October 1, 2001, the beneficiary of an approved I-140 Petition with an approved National Interest Waiver based on clinical service in a medically underserved area may file an Adjustment of Status Application even if the physician received a J-1 waiver of the two year foreign residence requirement and is still fulfilling the three-year medical service requirement in H-1B status pursuant to section 214(l) of the INA. USCIS, however, may not approve the Adjustment of Status application until the physician has complied with the service requirements for both the J-1 Waiver and the National Interest Waiver.
39 Pursuant to the USCIS Interoffice Memorandum of Mr. Paul Virtue, Executive Associate Commissioner, dated February 17, 1998, “[a]n alien who has received a USIA [now DOS] recommendation for a waiver of the foreign residence requirement is deemed to have met the requirement of 8 CFR 245.1(c)(2).” Therefore, the H-1B Petition can be submitted with a copy of the DOS recommendation letter rather than waiting for the final approval notice from USCIS.
40 Immigration and Nationality Technical Corrections Act of 1994 (INTCA), Pub. L. No. 103-416, 108 Stat. 4305; INA §214(l). Of the 30 Conrad waiver slots allocated to each state, 10 may be used as “Flex” slots for those physicians serving populations which, while not located in federally designated shortage areas, are located in areas serving a patient population that is experiencing a medical shortage. Again, how these flex slots will be used, if at all, is determined by each individual state.
waiver slots to distribute each Fiscal Year in a manner that each sees fit (i.e., based on how the state believes that those limited slots can best be utilized to serve the state’s patient population). It is important to stress that most states favor allocating their Conrad 30 waivers to “primary care” physicians, rather than specialists. While primary care generally includes Family or General Medicine, Internal Medicine and Pediatrics, note that each state defines “primary care” differently. Interestingly, all but a few of the states include Obstetrics and Gynecology in their definitions and approximately 80% of the states also include Psychiatry. Some states also include Geriatrics, Emergency Medicine, Adolescent Medicine, Anesthesiology and/or Hospitalists, while others do not.

When determining how to distribute their 30 J-1 Conrad Waivers and typically faced with a request for more slots than supply permits, states engage in a thoughtful, almost “King Solomon-like” balancing approach. It is therefore critical for the immigration practitioner to carefully review the policies of the particular state prior to accepting any Conrad 30 waiver in order to anticipate the likelihood of that state ultimately granting such waiver. This includes contacting the designated administrator of the state’s Department of Public Health to review that state’s current J-1 waiver program policies, for although most states do publish their J-1 waiver criteria and procedure on their websites, published information may not be up to date and/or the J-1 slots already exhausted. Generally, Conrad 30 waiver applications must demonstrate that the facility not only falls within an underserved area, but that the J-1 sponsor has been unable to recruit sufficient U.S. workers to serve its patient population.

Finally, practitioners should be aware that these slots become available on October 1, the beginning of each Fiscal Year, and disappear very quickly. For example, Conrad 30 waiver requests in New York historically have far exceeded supply. For this reason the Conrad 30 administrator in New York will not even consider any Conrad 30 waiver if another basis for a J-1 waiver (e.g. the Appalachian Regional Commission) exists. In the state of Pennsylvania, slots fill quickly and it is hence wise to speak to the state administrator well in advance of filing an application to be certain that a number remains available. Therefore, it is also helpful to check in with the state periodically throughout the preparation of the J-1 waiver application to ensure that there are slots that remain available. Once a Conrad 30 J-1 waiver is granted, the physician is required to provide direct clinical services in an underserved area in H-1B status for three years before he/she can submit an application for LPR status.

Procedure for obtaining Conrad 30 waiver:

a. Applicant submits online J-1 Visa Waiver Recommendation Application (Form DS-3035) to obtain a DOS case number and sends the Application, along with fee and supporting documents to the DOS’ Waiver Review Division.

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42 Id.
43 A comprehensive chart summarizing the general rules for each state’s Conrad 30 program, prepared by Siskind Susser, PC is available at www.visalaw.com/IMG/state30.pdf. It cannot be stressed enough that, due to constant changes in state contacts as well as in procedure, the continued accuracy of such information should be carefully checked prior to commencing a waiver.
45 In Pennsylvania, Karen Heim currently serves as the J-1 Program administrator within the Department of Health.
46 Supra note 37. Although the physician cannot submit the I-485 Application to Adjust Status to that of LPR until the service commitment has been satisfied, during this time, the physician’s J-1 sponsoring employer may file the first two steps of the permanent residency process—the PERM Application with the DOL and, once certified, the I-140 Petition with USCIS.
b. Applicant submits J-1 waiver application to the state’s Department of Public Health or equivalent agency;
c. If support of waiver is granted, the state’s Department of Public Health recommends waiver to DOS’ Waiver Review Division;
d. If support of waiver is granted, DOS recommends waiver to USCIS; e. If USCIS concurs with DOS, USCIS issues final approval.

2. Exceptional Hardship Waivers

In addition to the federal IGA and State Conrad 30 waivers discussed above, a physician may apply for a J-1 waiver by establishing that his/her departure from the U.S. would cause “exceptional hardship” to a U.S. Citizen or Lawful Permanent Resident spouse or child. Such hardship must be economic, physical, psychological, or a combination of the above. The courts have made it quite clear that “the usual difficulties attendant to mere family separation will not satisfy the standard for this waiver”. In other words, “exceptional” means exceptional and this harsh standard is routinely followed, despite the division of families. It is critical to demonstrate that such exceptional hardship will result regardless of whether the spouse or child returns “home” with the exchange visitor, or remains alone in the U.S. for two years while the J-1 physician complies with the two year home residence requirement in his/her home country. In those limited circumstances where a J-1 waiver is granted based on demonstrating such exceptional hardship, the J-1 physician can then immediately apply for LPR status, as discussed below.

Procedure for obtaining Exceptional Hardship waiver:

a. Applicant submits the Application for Waiver of the Foreign Residence Requirement (Form I-612) to the USCIS;
b. Either before or after submitting Form I-612, applicant must complete the online J-1 Visa Waiver Recommendation Application (Form DS-3035) to obtain a DOS case number and send the Application, along with fee and supporting documents, to the DOS’ Waiver Review Division;
c. If USCIS finds exceptional hardship, case is transferred to DOS’ Waiver Review Division for review;
d. If DOS supports waiver, case is sent back to USCIS to issue final approval.

3. Persecution Waivers

A J-1 physician may also apply for a J-1 waiver by establishing that he/she would be subject to persecution on account of race, religion or political opinion. Unlike an asylum claim, where the applicant must show that he/she has a “well-founded fear of” persecution, a J-1 persecution waiver requires the applicant to demonstrate that he/she would be subject to persecution on account of race, religion or political opinion.

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47 Again, pursuant to the USCIS Interoffice Memorandum of Mr. Paul Virtue, Executive Associate Commissioner, dated February 17, 1998, “[a]n alien who has received a USIA [now DOS] recommendation for a waiver of the foreign residence requirement is deemed to have met the requirement of 8 CFR 245.1(c)(2).” Therefore, the H-1B Petition can be submitted with a copy of the DOS recommendation letter rather than waiting for the final approval notice from USCIS.
48 Supra note 27.
51 Supra note 27.
52 Pursuant to INA §208(a)(1), an individual who is physically present in the United States can apply for asylum if they meet the Act’s definition of “refugee.” Pursuant to INA §101(a)(42), a refugee is defined as someone who is “unable or willing to
applicant must satisfy a stronger standard: he/she must show that he/she “would be” subject to persecution.\textsuperscript{53} For this reason, the foreign national physician contemplating a persecution waiver may, if otherwise eligible, prefer to seek asylum in the U.S., utilizing this lesser standard of proof. Of equal importance, once the J-1 physician is granted asylum he/she no longer is required to obtain a J-1 waiver and ultimately may apply for LPR status based on such asylum grant.\textsuperscript{54}

Procedure for obtaining Persecution waiver:

a. Applicant submits directly the Application for Waiver of the Foreign Residence Requirement (Form I-612) to USCIS;

b. Either before or after submitting Form I-612, applicant must complete the online J-1 Visa Waiver Recommendation Application (Form DS-3035) to obtain a case number and send the Application, along with fee and supporting documents, to the Department of State’s Waiver Review Division.

c. If USCIS finds well-founded fear of persecution, the case is transferred to DOS’ Waiver Review Division for review;

d. If DOS supports waiver, case is sent back to USCIS to issue final approval.

Immigrating the H-1B Physician

Unlike their J-1 counterparts, H-1B physicians have the good fortune of not being subject to a foreign residence requirement and, if they choose to remain in the U.S. after completion of their graduate medical training or other temporary H-1B employment position, may, if they have obtained sponsorship through an employer or are able to self-sponsor\textsuperscript{55}, proceed directly to the finish line—LPR status. However, there is a catch: foreign workers are generally only permitted to remain in the U.S. in H-1B status for a maximum period of six years,\textsuperscript{56} after which time the individual must leave the U.S. for at least one year before he/she can re-enter the U.S. in H-1B classification.\textsuperscript{57} As with much of immigration law, there is an exception to this six year H-1B cap: a physician in H-1B status may extend his/her H-1B status beyond six years if the process for obtaining LPR status has been commenced on their behalf early enough. Specifically, if an Application for Permanent Employment Certification Form ETA 9089 (“PERM Application”) or I-140 Immigrant Petition was filed on the physician’s behalf and has been pending for more than 365 days, the physician is statutorily eligible to obtain a one year extension of his/her H-1B status.\textsuperscript{58} If both the PERM Application and the I-140 Immigrant Petition filed on behalf of the physician have been approved, he/she will be able to obtain a three year extension of H-1B status (beyond the six years) provided he/she is unable to apply for LPR status because of “visa retrogression.”\textsuperscript{59} However, even if the physician is able to apply for LPR status because his/her Priority return” to their home country “because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a social group, or political opinion.”

\textsuperscript{53} Supra note 27.

\textsuperscript{54} 8 CFR §209.2(b).

\textsuperscript{55} Supra note 18.

\textsuperscript{56} INA §214(g)(4).

\textsuperscript{57} 8 CFR §214.2(h)(13)(iii)(A).

\textsuperscript{58} AC21 §106 (Pub.L. 106-313).

\textsuperscript{59} Pursuant to AC21 §104(c), the Foreign Worker’s H-1B status can be extended until his Application for Adjustment of Status has been adjudicated. INS Memorandum, M. Pearson, “Initial Guidance for Processing H-1B Petitions as Affected by the ‘American Competitiveness in the Twenty-First Century Act’ (Public Law 106-313) and Related Legislation (Public Law 106-311) and (Public Law 106-396)” (June 19, 2001). “Visa retrogression” signifies that an immigrant visa is not immediately available, as reflected on the Department of State-issued Visa Bulletin available online at http://travel.state.gov/visa/frvi/bulletin/bulletin_1360.html.
Date is current, the physician may still extend his/her H-1B in one year increments if the PERM Application or I-140 Immigrant Petition was submitted more than 365 days before the requested start date on the H-1B Extension Petition. It should also be noted that the physician may “recapture” any time he/she has spent outside of the U.S. Therefore, it is critical to carefully track when a foreign physician will exhaust the maximum six years of allotted H-1B time and to start the process of pursuing LPR status on behalf of that physician as early as possible.

Obtaining Lawful Permanent Resident (LPR) Status

Unless the foreign physician meets the criteria set forth at 8 CFR §204.5(h) and (i) for classification as an “Alien of Extraordinary Ability” or “Outstanding Professor/Researcher” or has an alternative means by which to obtain LPR status (such as a National Interest Waiver, a Family-Based Petition, Asylum, or Diversity Visa Lottery Application), the general manner of obtaining LPR status is to undergo the labor certification, or PERM, process with the DOL. PERM is a formulaic, rigid, unforgiving DOL-administered program in which an employer is required to conduct a test of the job market, through recruitment, to establish that there are not willing, able and qualified U.S. workers to fill the advertised position. Once this test has been met, the employer then submits a PERM Application electronically to the DOL attesting to the same. If (and when) the DOL has “certified” the PERM Application, the employer may proceed to the next step—filing the I-140 Immigrant Petition with USCIS. Depending on the availability of immigrant visas, the foreign physician may also submit his/her I-485 Application to Adjust Status to that of LPR to USCIS.

The procedure for filing and obtaining an approved PERM Application on behalf of a foreign physician, like all PERM Applications, is quite complicated and is the subject of many articles and AILA message board discussions. Such complexity has been further fostered by a rash of recent decisions by both the DOL and USCIS in adjudicating PERM Applications and I-140 Petitions filed on behalf of medical residents challenging whether such positions are sufficiently “permanent” for pursuing LPR status. In fact, the Philadelphia area, where many of the nation’s first hospital and first medical residency program were founded, is at the forefront of these challenges.

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60 The Priority Date is the date the PERM Application is submitted to the U.S. Department of Labor or (for a classification which does not require a certified PERM Application from the U.S. Department of Labor) the date the I-140 Immigrant Petition is submitted to USCIS.

61 Pursuant to the USCIS Interoffice Memorandum of Mr. Michael Aytes, Acting Associate Director for Domestic Operations, dated October 21, 2005, “any days spent outside of the United States during the validity period of an H-1B or L-1 petition will not be counted toward the maximum period of stay in the United States in H-1B or L-1 status”.


63 For a description of such process see DAVID STANTON MANUAL ON LABOR CERTIFICATION, (Susan J. Cohen & Jane W. Goldblum eds., AILA 2008-09). Note that the procedures pertaining to the filing of PERM applications on behalf of physicians are the same as those required to apply for many other types of hospital personnel such as administrators, computer personnel, etc.

64 See supra note 59.


66 A number of Philadelphia firms, including that of the authors of this article, are involved in this litigation involving whether medical resident positions are sufficiently “permanent” for purposes of pursuing LPR status. For a detailed discussion of this litigation, see id, as well as the other article included in this handbook, Robert Aronson and Wendy Castor Hess, PERM Filings for Residents, Interns and Physicians: Variations on a Theme by Hippocrates, in DAVID STANTON MANUAL ON LABOR CERTIFICATION (Weber, Cletus ed., AILA forthcoming 2012).
NON-PHYSICIAN HEALTH CARE WORKERS

Much like physicians, there is a growing need for non-physician health care workers. The historical acknowledgement that a shortage of these critical health care professionals has existed is reflected in the DOL’s pre-determinations, in certain areas, that “there are not sufficient United States workers who are able, willing, qualified and available”67 to fill such positions and thus the ability to bypass the usual lengthy PERM process. Specifically, U.S. immigration law continues to provide nonimmigrant and immigrant processes for non-physician health care professionals such as nurses, occupational therapists, and physical therapists to enter the U.S., not always, as will be shown, treating each category with the recognition of professionalism that it deserves. As noted above, this article is not intended to go into great detail regarding the various nonimmigrant and immigrant options available to non-physician health care workers, but instead provides general guidance, highlighting the problematic areas most often encountered.

Requirement of Section 343 Health Care Certification

One of the most often overlooked issues for non-physician health care workers is the requirement of section 343 health care certification. The Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (“IIRAIRA”), best known for the creation of 3 year, 10 year and permanent bars which preclude the immigration of many who are or were illegally present in the U.S.,68 also tremendously impacted the health care industry by introducing a new ground of inadmissibility for many health care workers.69 Specifically, IIRIRA’s section 343 amended section 212(a)(5) of the Immigration and Nationality Act (“INA”) by adding subsection (C) to the law. This section requires foreign nationals, other than physicians, who seek to enter the U.S. to perform work as health care workers, to obtain health care certification prior to admission to the U.S.70 Three years after the passage of IIRIRA, the Nursing Relief for Disadvantaged Area Act of 1999 (“NRDAA”) was passed and codified at INA § 212(r), which “established an alternative to the health care certification requirement for certain nurses already

67 20 CFR §656.5.
68 INA §212(a)(9)(B)(i) and §212(a)(6)(A)(i).
69 IIRAIRA §343 codified at INA §212(a)(5)(C) states: UNCERTIFIED FOREIGN HEALTH-CARE WORKERS.—Any alien who seeks to enter the United States for the purpose of performing labor as a health-care worker, other than a physician, is excludable unless the alien presents to the consular officer, or, in the case of an adjustment of status, the Attorney General, a certificate from the Commission on Graduates of Foreign Nursing Schools, or a certificate from an equivalent independent credentialing organization approved by the Attorney General in consultation with the Secretary of Health and Human Services, verifying that-
(i) the alien's education, training, license, and experience-
(I) meet all applicable statutory and regulatory requirements for entry into the United States under the classification specified in the application;
(II) are comparable with that required for an American health-care worker of the same type; and
(III) are authentic and, in the case of a license, unencumbered;
(ii) the alien has the level of competence in oral and written English considered by the Secretary of Health and Human Services, in consultation with the Secretary of Education, to be appropriate for health care work of the kind in which the alien will be engaged, as shown by an appropriate score on one or more nationally recognized, commercially available, standardized assessments of the applicant's ability to speak and write; and
(iii) if a majority of States licensing the profession in which the alien intends to work recognize a test predicting the success on the profession's licensing or certification examination, the alien has passed such a test or has passed such an examination.
For purposes of clause (ii), determination of the standardized tests required and of the minimum scores that are appropriate are within the sole discretion of the Secretary of Health and Human Services and are not subject to further administrative or judicial review.
70 Id.
licensed in the United States.” Seven years later, on July 25, 2003, USCIS issued the final rule implementing the health care certification requirement, which took effect September 23, 2003.

Pursuant to such laws and regulations, the following non-physician health care workers are required to obtain section 343 health care certifications pursuant to 8 CFR §212.15(c):

1) Licensed Practical Nurses, Licensed Vocational Nurses, and Registered Nurses (RNs);
2) Occupational Therapists;
3) Physical Therapists (TPs);
4) Speech Language Pathologists and Audiologists;
5) Medical Technologists (Clinical Laboratory Scientists);
6) Physician Assistants; [and]
7) Medical Technicians (Clinical Laboratory Technicians).

It is important to note that 8 CFR §212.15(c) specifies that 343 health care certification is required for medical technologists and medical technicians who are clinical scientists/technicians, but not to “aliens seeking admission to the United States to perform services in a non-clinical health care occupation.” Therefore, if the non-physician health care worker will not be performing clinical work in the U.S., the health care certification is not required.

**Obtaining the Health Care Certification**

Once the immigration practitioner determines that the non-physician health care worker will be seeking admission into the U.S. to pursue one of the health care occupations listed under 8 CFR §212.15(c), health care certification, if not already obtained, must be sought through one of the organizations enumerated in 8 CFR §212.15(e). The most commonly used avenue of health care certification is through CGFNS.

CGFNS International, formerly the Commission of Graduates of Foreign Nursing Schools (“CGFNS”) and its division, the International Commission on Healthcare Professions (“ICHP”) is charged with issuing health care certificates known as a “VisaScreen®”, for nurses, physical therapists, occupational therapists, speech-language pathologists and audiologists, medical technologists, medical technicians, and physician assistants. CGFNS’ mission is to “protect the public by ensuring the integrity of health professional credentials in the context of global migration.”

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72 For an excellent in-depth explanation of this requirement see *id.*
73 8 CFR §212.15(c).
74 8 CFR §212.15(b)(2) defined non-clinical health care occupation as one “in which the alien is not required to perform direct or indirect patient care” which include occupations such as medical teachers, medical researchers, and managers of health care facilities. *Id.*
75 For a detailed discussion explaining how to navigate CGFNS’ certification procedure, see Donna Rae Richardson, Certification—How to Get over the Rainbow, in *IMMIGRATION OPTIONS FOR NURSES AND ALLIED HEALTH CARE PROFESSIONALS* 59 (James David Acoba et al. eds., 2009).
76 Like CGFNS, the Foreign Credentialing Commission on Physical Therapy (FCCPT) has been authorized by the USCIS to issue Comprehensive Credential Evaluation Review (Type I Certificate) certificates in the field of physical therapy to a foreign national who seeks to enter the United States as an immigrant or nonimmigrant for the primary purpose of performing labor as a physical therapist. In order to obtain the certificate, the foreign national physical therapist must 1) have graduated from a foreign physical therapy program that is recognized in the country of education by the appropriate ministry; 2) be eligible to practice as a physical therapist in the country of education, and if the foreign national possesses a license, the license must be in good standing; 3) pass the Test of English as a Foreign Language (TOEFL) examination; and 4) obtain a
In accordance with 8 CFR §212.15(f), CGFNS performs educational evaluation and license validation to ensure that all requirements are satisfied prior to issuing the health care certificate. To begin, CGFNS must determine whether or not the non-physician health care worker’s “education, training, license, and experience are comparable with that required for an American health care worker of the same type.” Second, authentication of the non-physician health care worker’s education, training, license and experience is required. Third, CGFNS must determine whether or not the non-physician health care worker’s education, training license and experience meet the applicable statutory and regulatory requirements for admission into the U.S. Fourth, the non-physician health care worker must pass a “test predicting success on the occupation’s licensing or certification examination”, and finally, English language proficiency must be evidenced.

CGFNS’ website provides detailed instructions for such educational evaluations and validation. Donna Rae Richardson of CGFNS discusses the “bumps in the road” encountered by foreign medical professionals when applying for the visa screen and offers the following advice:

Major reasons for delays include incomplete information submitted on the application; lack of signatures on the application, license validations, or transcripts; missing or incorrectly expressed theory and clinical hours; inconsistent dates between the application and documents; and lack of agreement between previous records for other services held by CGFNS/ICHP on the same applicant with the new application or submitted documents.

As stressed by CGFNS, it is not only critical to carefully “read all instructions to ensure accurate and complete answers”, but also to immediately request transcripts and license validations. CGFNS also cautions all applicants to ensure that their correct and entire name history is reflected in their determination that the education received was substantially equivalent to the current U.S. education for physical therapists. For more information about FCCPT and its certification requirements, see http://www.fccpt.org/apply/PrimaryServices/T1/TOEFL/index.asp (last visited Aug. 25, 2010). In addition, The National Board for Certification in Occupational Therapy (NBCOT) has been authorized by the USCIS to issue Visa Credential Verification Certificates (VCVC) to a foreign national who seeks to enter the United States as an immigrant or nonimmigrant for the primary purpose of performing labor as an occupational therapist. In order to obtain a VCVC from the NBCOT, the foreign national must possess the following: 1) education comparable with that required of an American occupational therapist; 2) fieldwork comparable with the requirements for an American occupational therapist (i.e. a minimum of 1,000 hours of successful fieldwork experience); 3) successful passage of an English Language Proficiency examination; 4) verifiable and unencumbered licensure; and 5) passage of the NBCOT Certification Examination for Occupational Therapist Registered OTR®. For more information about NBCOT and their certification requirements, see NBCOT website at http://www.nbcot.org/index.php?option=com_content&view=article&id=56&Itemid=78 (last visited Aug. 25, 2010).

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77 Supra note 75 at 59.
78 Id at 61 - 62.
80 8 CFR §212.15(f)(1)(ii).
81 8 CFR §212.15(f)(1)(iii).
82 8 CFR §212.15(f)(1)(iv).
83 8 CFR §212.15(g). The regulations list only three testing services that have thus far been approved to test for English language proficiency: Educational Testing Service (ETS), Test of English in International Communication (TOEIC) Service International, and International English Language Testing System (IELTS).
85 Supra note 75 at 62.
86 Supra note 75 at 63.
applications. For example, in India, educational and license records often use abbreviations of different names and reversed names in different certificates, which can cause confusion and great delay:

Applicants should ensure that their application and request authorizations reflect their correct and entire name history. Female applicants may have several name changes due to marriage, divorces, or widowhood. Such name changes have to be documented with birth certificates, marriage licenses, divorce decrees, and notarized statements. Dates of birth, graduation, and licensure should be written out. If a date discrepancy exists, the applicant should include a notarized statement of explanation. School information should be complete. Do not use abbreviations or initials. Using the exact, full name of schools lessens confusion. If the school is St. Anthony of Padua, state that, as there may be more than one St. Anthony school of nursing in an area. The dates of beginning and completing education are important to document the duration of education. Although CGFNS/ICHP does not expect that the applicant will remember the exact day of the month, an applicant should remember the year of completion and when a school year runs in his or her country of education.

Furthermore, and again as stressed by CGFNS in its instructions, all documents pertaining to professional education must be forwarded directly from the Medical Institution/University to CGFNS to attempt to prevent the receipt of fraudulent and/or altered documents, which, unfortunately, is quite common.

Finally, since time is typically of the essence and overseas educational institutions may be operating on a different level of urgency and speed, it is always helpful to advise clients, whenever possible, to appear in person at the overseas institution (or have a friend or family member appear) and offer to pay any additional costs for forwarding an “expedited” transcript to CGFNS. Of course, Federal Express/DHL is always highly recommended when sending the educational documents directly from the institution to CGFNS since the regular mail in some countries takes months to arrive (if it arrives at all).

Alternative to Health Care Certification

In lieu of the certification, nurses may obtain a certified statement if they meet the requirements under 8 CFR §212.15(h). Nurses may obtain such certified statements from CGFNS if: 1) the nurse has a valid and unrestricted license as a nurse in a state where the nurse intends to work and such license is verified by the state as being authentic and unencumbered; 2) the nurse passes the National Council Licensure Examination (NCLEX); and 4) the nurse graduated from a nursing program in a designated country.

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87 Id.
88 Id.
89 CGFNS has reported incidents of fraud such as Nigerian applicants claiming to be licensed practical nurses in Nigeria when no such program existed in Nigeria, and fraudulent licensed practical nurse documents being issued by “bogus” schools in the Caribbean. See Minutes of AILA-CGFNS Liaison Meeting (April 14, 2006), published on AILA InfoNet at Doc. No. 06061671 (posted June 16, 2006).
90 8 CFR §212.15(h)(2)(iv) lists the designated countries: Australia, Canada (except Quebec), Ireland, New Zealand, South Africa, the United Kingdom, or the United States. Other countries may be designated by “unanimous agreement of CGFNS and any equivalent credentialing organizations which have been approved for the certification of nurses and which are listed at paragraph (e) of this section”. 8 CFR §212.15(h)(2)(iv). According to CGFNS, such countries include Barbados, Jamaica, and Trinidad and Tobago. See CGFNS/ICHP Visascreen®: Visa Credentials Assessment Program: Applicant Handbook (2008 Ed.) found at http://www.cgfns.org/files/pdf/apps/VS_Handbook.pdf (last visited August 25, 2010).
which provides instruction in English. It is important to note that despite the regulations that allow qualified nurses to obtain certified statements in lieu of the certification itself, such alternative is open only to nurses who hold unrestricted licenses in Florida, Georgia, Illinois, Michigan, and New York.

Once issued, health care certificates are valid for five years after their issuance date, but may be reissued. Importantly, health care certification, while required, does not need to be submitted initially with an Application to Adjust Status. However, from a practical point of view, it is preferable to have the certificate on hand at the time of submission of the Application to Adjust Status and submit it along with the same for several reasons. First, it is time consuming to obtain these certificates and not within the applicant’s control due to the multi-factorial process. If USCIS requests such health care certificate and the foreign health care professional worker cannot produce it within the USCIS allotted deadline, the case will be denied. As USCIS filing fees are becoming increasingly expensive, a wise practitioner will caution clients of the financial risk of filing an Application to Adjust Status without the requisite health care certificate. Second, USCIS seems to be doing a “flip flop” on their policy regarding this issue. Specifically, on September 22, 2003, USCIS issued a memo indicating that certification was required at the time of submission, but on October 1, 2003 reversed and reverted to its prior practice of allowing post-filing submission of the health care certificate or certified statement. Although this remains the policy, as noted above, attorneys who do so proceed at their own risk.

State Licensure

All foreign medical professionals in the U.S. must comply not only with U.S. Immigration laws (i.e. obtaining health care certification), but also state licensure requirements which, logically, varies greatly from state to state. For example, in order for professional nurses to pursue LPR status, they must possess one the following three: 1) a Certificate from the Commission on Graduates of Foreign Nursing Schools (CGFNS); 2) a full and unrestricted license to practice nursing in the state of intended employment; or 3) passage of the National Council Licensure Examination for Registered Nurses (NCLEX-RN).

Specifically, in the Commonwealth of Pennsylvania, a nurse must meet the following requirements in order to obtain licensure: 1) pass the written examination as provided by the State Board of Nursing of the Commonwealth; 2) be of good moral character; 3) complete work equal to a standard high school course; and 4) complete an approved program of professional nursing.

For guidance as to where to start with state-by-state licensing entities, an excellent source is [http://www.visalaw.com/IMG/resources.html](http://www.visalaw.com/IMG/resources.html). In addition, for more information pertaining to other

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91 8 CFR §212.15(h).
93 See 8 CFR 212.15(n) (4); 8 CFR 212.15(k)(4)(viii).
95 USCIS Headquarters Response to Issues Raised by AILA at the AILA/USCIS Benefits Liaison Meeting on October 1, 2003 (Oct. 1, 2003), [published on AILA InfoNet at Doc. No. 03112547](http://www.visalaw.com/IMG/resources.html) (posted Nov. 25, 2003). For further details regarding USCIS policy on submission of the health care certification when applying for adjustment of status, see [supra note 71 at 10](http://www.visalaw.com/IMG/resources.html).
96 20 CFR § 656.15(c)(2).
state’s licensure requirements for nurses, as well as for other non-physician health care workers, the excellent treatise, “Immigration Options for Nurses and Allied Health Care Professionals”, 98 contains state-by-state licensing charts for nurses, occupational therapists, physical therapists, medical technologists, and speech therapists.

**Immigrant Petition Process for “Schedule A” Non-Physician Health Care Professionals**

All health care professionals must file applications with both the DOL and USCIS in order to obtain LPR status. As described above in the physician section, the DOL procedure typically involves a “PERM process” in which the petitioning employer must establish that there are not sufficient U.S. workers who are able, willing, qualified, and available to perform the sponsored job.99 Only once the PERM Application is certified may the foreign health professional file the next stage of the procedure, the I-140 Immigrant Petition, directly with USCIS. However, two categories of health care professionals, professional nurses (RN) and physical therapists, fall within a privileged health care worker category: they are statutorily exempt from this DOL requirement because the DOL has pre-determined that a shortage of such professionals exists.100 These two categories of non-physician health care professionals may “fast-track” the process and apply directly to USCIS under the DOL’s “Schedule A, Group I” program.101 As this is a process with some “wrinkles”, it is helpful to review the “Schedule A, Group I” processing for nurses as a partial template for their physical therapists counterparts.

As noted above, professional nurses may pursue LPR status through the DOL’s “Schedule A, Group I” abbreviated process.102 Therefore, the labor market does not need to be tested before an I-140 Immigrant Petition is filed with USCIS.103 Note, however, that the notice requirement pursuant to 20 CFR § 656.10(d) still must be satisfied104 before the I-140 Immigrant Petition, including the signed and completed but not certified PERM Application, is submitted to USCIS. It is this area that immigration practitioners have experienced perhaps the greatest difficulties.

Pursuant to 20 CFR §656.10(d)(1)(i), if a union for employees in the “occupational classification for which certification is sought in the employer’s location(s) in the area of intended employment” exists,105 the union representative or bargaining representative must be appropriately notified of the job opening. Documents to evidence that such notice was given may include a copy of the letter and the PERM Application that was sent to the representative.106 If there is no union at the location of intended employment, the notice requirement must be fulfilled through the posting of a notice at the location for at least 10 consecutive business days.107 Practitioners are cautioned to keep in mind that even within the

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98 See IMMIGRATION OPTIONS FOR NURSES AND ALLIED HEALTH CARE PROFESSIONALS (James David Acoba et al. eds., 2009).
100 20 CFR §656.5.
101 20 CFR §656.5(a).
102 A “professional nurse” is defined as “a person who applies the art and science of nursing which reflects comprehension of principles derived from the physical, biological and behavioral sciences. Professional nursing generally includes making clinical judgments involving the observation, care and counsel of persons requiring nursing care; administering of medicines and treatments prescribed by the physician or dentist; and participation in the activities for the promotion of health and prevention of illness in others.” 20 CFR § 656.5(a)(3)(ii).
103 20 CFR § 656.15(c)(2) actually states that an “[a]pplication for certification of employment as a professional nurse may be made only under this §656.15(c) and not under §656.17.
104 20 CFR § 656.10(d).
105 20 CFR § 656.10(d)(1)(i).
106 Id.
107 20 CFR § 656.10(d)(1)(ii).
same hospital network, some hospital facilities are unionized whereas others are not. For this reason, prior to posting, it is critical to ascertain whether the particular hospital facility is a unionized facility. Of equal importance, although hospitals are open 24/7 and therefore consider themselves to be operating on a “business day”, until recently, USCIS and the DOL did not agree: Saturdays, Sundays, and holidays were not counted towards the 10 consecutive business days even though the hospital remained open.

In addition, if the employer normally utilizes “in-house media” to recruit for similar positions, such notice must also be posted through such media. Such notice must include the job description, rate of pay, the address of the certifying officer, and state that “the notice is being provided as a result of the filing of an application for permanent alien labor certification for the relevant job opportunity.”

Importantly, as in traditional PERM Applications, the notice must be “provided between 30 and 180 days before filing”. Therefore, in the case of I-140 Immigrant Petitions filed under “Schedule A, Group I” the I-140 Immigrant Petition can only be filed 30 days after the notice has been provided, but before 180 days have passed since the notice was provided.

Finally, although the PERM Application is not submitted to the DOL for “Schedule A, Group I” nurses, but rather directly to USCIS, the DOL has clearly stated that employers are still responsible for all costs associated with “any activity related to obtaining permanent labor certification” pursuant to 20 CFR § 656.12(b).

Other Miscellaneous Issues for Non-Physician Health Care Workers

Evaluation of Educational Credentials

In addition to securing the critical health care certification, non-physician health care works who have obtained degrees from non-U.S. institutions are required to obtain a credentials evaluation to establish that such education is equivalent to that offered by a U.S. institution. Depending upon the type of health care occupation, different entities are charged with the responsibility of reviewing the documents, verifying authenticity and issuing equivalency evaluations.

The “Immigration Step-Child” the Foreign Nurse

Ask any nurse whether he/she considers him/herself to be a true “professional” and the answer is always an unequivocal “yes”. That is why it is particularly vexing to nurses that they are treated, under the immigration laws, as “step-children” to their physical therapy/occupational therapy and other health care colleagues. Specifically, unlike their colleagues whose positions fall within the definition of “professional/specialty occupations” required to be statutorily eligible to obtain H-1B visas, most nurses are ineligible for such classification because registered nurse (RN) positions are generally not

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108 Matter of Il Cortile Restaurant, 2010 PER 00683 (BALCA, October 12, 2010).
109 Supra note 106.
110 20 CFR § 656.10(d)(3)(i). Please review 20 CFR § 656.10(d)(3) and 20 CFR § 656.10(d)(6) for details regarding what must be included in such posting to satisfy the notice requirement under the PERM regulations.
111 20 CFR § 656.10(d)(3)(iv).
112 See ‘DOL Round 2 FAQs on the “Substitution Plus” Final Rule’ (Mar. 31, 2008), published on AILA InfoNet at Doc. No. 08040234 (posted Apr. 2, 2008), and also found at http://www.aila.org/content/default.aspx?docid=25097.
113 See supra note 76.
considered to be “specialty occupations”114 due to the fact that U.S. states do not normally require an individual to possess a bachelor’s degree in order to obtain RN licensure.115 Such disparate treatment limits the nonimmigrant visa options available to these nurses and may interfere with their ability to work for the sponsoring employer. Indeed, even if a nurse holds a bachelor’s degree in nursing, he/she is generally unable to obtain H-1B status116 and work for the sponsoring employer while pursuing the permanent residency process (which can take up to eight years due to the current visa backlog in the third preference employment-based category).117 Understandably, few, if any, employers in urgent need of nursing staff are willing to wait years for that employee to start working and hence many healthcare institutions shy away from sponsoring nursing staff.

**Conclusion**

The availability of qualified medical professionals to serve an aging and increasing U.S. patient population is an increasingly critical issue that needs to be quickly (and appropriately) addressed by the immigration system. To date, it, like so many other portions of the immigration law, is being held hostage by a Congress paralyzed at the very concept of touching any bill in which the word “immigration” appears. Without much-needed changes in the law to facilitate the immigration of foreign health care professionals, our U.S. medical community is left with very limited immigration avenues to pursue as it seeks to provide health care services to a nation even more “at risk” than it could ever begin to guess.

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114 8 CFR §214.2(h)(4)(iii)(A) defines “specialty occupation” as a positions that “meet[s] one of the following criteria: (1) A baccalaureate or higher degree or its equivalent is normally the minimum requirement for entry into the particular position; (2) the degree requirement is common to the industry in parallel positions among similar organizations or, in the alternative, an employer may show that its particular position is so complex or unique that it can performed only by an individual with a degree; 3) the employer normally requires a degree or its equivalent for the position; or 4) the nature of the specific duties are so specialized and complex that knowledge required to perform the duties is usually associated with the attainment of a baccalaureate or higher degree.” See Klari B. Tedrow, Immigrant and Nonimmigrant Visas for Professional Nurses, in IMMIGRATION OPTIONS FOR NURSES AND ALLIED HEALTH CARE PROFESSIONALS 33, 39 - 41 (James David Acoba et al. eds., 2009). 8 CFR §214.6; 8 CFR §214.6(c).

115 North Dakota used to be the only state that required an individual to possess a BSN in order to be licensed as an RN in the state. However, the BSN requirement was repealed in 2003.


117 I-140 Immigrant Petitions filed pursuant to the DOL’s “Schedule A, Group I” process are third preference employment-based category petitions. Currently, there is a tremendous visa backlog for the third preference employment-based category. Specifically, according to the Department of State’s February 2011 Visa Bulletin, the priority date for the third preference employment-based category is February 22, 2006 for foreign nationals not born in India or China, December 1, 2004 for foreign nationals born in mainland China, and August 15, 2002 for foreign nationals born in India. See Visa Bulletin, available online at http://travel.state.gov/visa/bulletin/bulletin_5113.html.
This article focuses on labor certification issues specific to Physicians. As an overview observation, this discussion is structured metaphorically along the musical form of “theme and variation” with an injection of some disharmonious atonality arising from a recent series of decisions that reverse a line of previous case adjudications on the definition of “permanence.”

The basic “theme” of “normal” labor certification application practice applies fully to Physicians, i.e., the employer bears the same burden of engaging in stipulated recruitment/advertising activity in order to show that the alien physician’s employment will not harm the U.S. labor market, either by taking a job away from a minimally qualified U.S. worker (or, for college and university teachers, to show that the alien is more qualified than any U.S.-worker applicant), and/or by adversely affecting wages and working conditions for similarly employed workers in the statistical reporting area.

But Physicians also have certain unusual employment and practice characteristics that inject various (sometimes disharmonious) “variations” to the labor certification application process. Physicians are subject to multi-tiered credentialing and licensure obligations sourced both in the medical profession and the state boards of medical licensure; they are required to undertake extensive periods of professional preparation that combine elements of employment, education, and training; there are differing practice modalities for physicians working in community-based settings, academic institutions, for-profit settings, and government entities; the range of

-- ROBERT D. ARONSON is the Managing Attorney of Aronson & Associates, based in Minneapolis, MN. His legal practice is focused on employment-based immigration with a particular emphasis on immigration benefits for physicians, biomedical researchers, and academic personnel. He is the past Chair of the AILA Healthcare Committee and was appointed as the immigration legal advisor to the Congressionally-created advisory body to the Secretary of Health and Human Services. He has authored over 70 articles on various aspects of immigration law—in particular, immigration law and policy for International Medical Graduates. He is a graduate of the Indiana University School of Law and was a Fulbright Fellow at the law schools of Harvard University and Moscow State University. In 2011, Mr. Aronson was honored as one of three Alumni of Distinguished Merit by the Indiana University School of Law.

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WENDY CASTOR HESS is a partner at Goldblum & Hess, based in Jenkintown, PA. She currently serves as the Chair of the Philadelphia Bar Association’s Immigration Committee, as Co-Vice Chair of the Pennsylvania Bar Association’s Immigration Section and as Co-Chair of the AILA Philadelphia USCIS liaison committee. A former staff Attorney with the U.S. Department of Justice, Board of Immigration Appeals, Ms. Hess is a frequent speaker at national immigration conferences and the author of numerous immigration articles, especially in the medical and employer sanction fields. Ms. Hess, who is fluent in Spanish, is listed in Best (Immigration) Lawyers in America and the International Who’s Who of Corporate Immigration Lawyers.

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independence exercised by a Physician spills over into certain atypical employment situations that differ from the “normal” employer-employee relationships. In addition, there is usually a high level of involvement in permanent resident matters for Physicians by the employer, oftentimes the community, and by the Physician beneficiary him- or herself—each with its own expectation of the process. In short, it is incumbent upon the practitioner to understand, not only the mechanisms of the labor certification application process, but also the overall professional environment governing the practice of medicine in this country.

Owing to a wide variety of factors, labor certification practice for Physicians requires careful attention and planning to minimize the chances of denial, not only at the labor certification stage, but at the I-140 and I-485 stages, as well. We will first look at labor certification issues particular to Physicians early in their careers—specifically, at the stage of being Medical Trainees (i.e., Interns, Residents and Fellows). We will then turn to several issues pertinent to Physicians in the labor certification process that require careful crafting, including foreign language requirements, timing and drafting issues, and “Special Recruitment” cases (formerly “Special Handling”).

Next, we will move to a discussion of employer identity, which oftentimes does not fully or directly track the source of the Physician’s compensation, since a community’s hospitals are oftentimes highly involved in the recruitment and initial compensation of the Physician. We will observe that the federal laws known as the Stark Laws impact how the labor certification is prepared, due to the need to avoid a denial at the I-140 stage on the issue of ability to pay. Finally, we will look briefly at the National Interest Waiver alternative as specifically applicable to Physicians and present some analytic considerations in determining whether a Physician’s case should be handled under the National Interest or the labor certification procedures.

**Issues Particular to Medical Trainees (Interns, Residents and Clinical Fellows)**

We begin our discussion by examining labor certification issues that arise for Physicians who have just begun their careers, or for primary care/general practitioners who have sought additional medical training in a specialty. In most labor certification cases, a Physician will have completed his or her period of Graduate Medical Education (GME) before commencing the permanent residence process. That means that the job forming the basis of the labor certification application is of ongoing existence and can be expected to last for an indefinite and presumably lengthy period of time, in theory, for the rest of the physician’s career. In those more typical labor certification cases, it is certain that the Physician’s employment will satisfy the Department of Labor’s (DOL) definition of being “permanent, full-time work by an employee for an employer other than oneself,” regardless of whether the employment is performed under contract or at will.

But what about Physicians who are still in their period of GME? The increasing prevalence of International Medical Graduates (IMGs) who are in H-1B status to pursue their GME has resulted in increased consideration as to whether it would be possible to file a labor certification for the positions of Intern, Resident and/or Fellow. The lengthy period of time required for many GME programs—especially in various medical specialties and sub-

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118 20 CFR §656.3. We are assuming in this section that the sponsored alien employee does not have an ownership interest in the employer that could lead to an audit and potentially a denial. While anecdotal evidence is always to be treated circumspectly, in at least one recent experience of the authors in a non-physician case, the fact that the sponsoring employer was 100 percent owned by the alien’s brother-in-law did not bar certification of the ETA Form 9089 because the employer provided clear evidence of having considered all U.S.-worker applicants, as well as the fact that the hiring decision-maker was not the family member but rather was an executive-level official of the company with sufficient independence to conduct the recruitment as required by the regulations. See 20 CFR §656.17(f).

119 As opposed to doing residency in J-1 status through sponsorship by the Educational Commission for Foreign Medical Graduates (ECFMG), followed by the need for a J-1 waiver which, in most cases, results in delaying devoting serious attention to seeking permanent residence.
specialties—combined with the finite period of six years of H-1B eligibility, make it highly desirable, if possible, to initiate a case for permanent residence during the period of medical training.

So the basic issue becomes: can GME positions be considered as meeting the DOL standards for “permanent full-time work” so as to enable an employer to file a labor certification application? If so, what are the legal and practical considerations in such labor certifications?

At the outset, we wish to define briefly the terminology and abbreviations used in this section in the medical training context. GME refers to periods of medical training that occur following the issuance of a Medical Doctor (MD) degree. The overall generic term in our discussion of Physicians undertaking GME is “Medical Trainee.” A Medical Trainee is already a Physician, and the purpose of doing GME is to gain advanced, refined medical skills within the profession. GME is employment in which a Physician, acting under the supervision of more senior practitioners, provides medical treatment services to patients. But GME also has heavy overtones of both education and training. There are three subgroups within GME: Interns, Residents, and Fellows. We will use the term “Intern” to refer to a medical school graduate who is in Post-Graduate Year One (PGY-1). We will use the term “Resident” to refer to a Physician who is doing further advanced training in specified medical disciplines (disproportionately, although not exclusively, in Primary Care medical disciplines) in Post-Graduate Years Two and above (PGY-2 & 3 or PGY 2+). We will use the term “Fellow” to describe more advanced medical training programs in specialized medical disciplines as normally required to fulfill standards set by the relevant American Board of Medical Specialties for Board-eligibility purposes.

Is the Job “Permanent?”

For Medical Trainees, a threshold question is whether or not the position constitutes “permanent” employment that can serve as the subject of a labor certification case (under the general idea that the purpose of the labor certification is to allow the alien to perform the duties at the time the alien is granted permanent resident status through either the approval of an I-485 application by U.S. Citizenship and Immigration Services (USCIS) or by being admitted to the United States on an immigrant visa issued by a U.S. Embassy or Consulate overseas).

At first glance, the answer would seem to be a simple “no” for all medical-training positions. After all, GME positions are limited to finite periods of training and one cannot be a physician-in-training forever. Without exception, each state requires a Physician to have completed certain stipulated periods of residency training at an accredited program as a term of medical licensure, and there are additional pressures to gain American Board Eligibility/Board Certification (commonly denoted as BE/BC) in order to practice in a specific medical discipline. Therefore, since Training cannot be a permanent, open-ended state of existence, it follows that a labor certification application cannot be filed for a Medical Trainee. Right?

We believe that the analysis is a little more nuanced. Until recently, the DOL’s Board of Alien Labor Certification Appeals (BALCA) had made quite clear that various positions in GME, i.e., the positions of Intern,

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120 See INA §214(g)(4).

121 The American Board of Medical Specialties (ABMS), a not-for-profit organization, assists 24 approved medical specialty boards in the development and use of standards in the ongoing evaluation and certification of physicians. The purpose of the BC/BE designation is to confirm a Physician’s fulfillment of certain training and professional standards indicating a desired level of medical competence in the field of practice. www.abms.org/.
Resident and Fellow, can be the subject of a permanent labor certification. The DOL regulations at 20 CFR §656.3 do not define the term “permanent.” The definition of “permanent” is instead found in BALCA case law, relatively recently restated in the case In re Crawford & Sons. According to Crawford, “permanent” employment is employment that can be continuous or carried on throughout the year, whereas employment of the kind exclusively performed at certain seasons or periods of the year cannot be considered permanent. Crawford involved the position of Landscape Gardener as opposed to a Medical Trainee, but its central holding (and that of its predecessor case, the Vito Volpe decision) provides the definition of “permanent” that should be applied to all labor certification cases, including to Physicians who are working as Medical Trainees. Crawford holds that the duties of Landscape Gardener cannot be performed year-round and thus are not “permanent” because there is necessarily a part of each year in the winter where the duties simply cannot be performed. Crawford contrasts Landscape Gardeners with Teachers and Professors. Teachers and Professors generally teach only during nine to ten months of each year, roughly the same amount of time a Landscape Gardener works during each year. However, Crawford noted that teaching duties, by their nature, may be performed continuously throughout the year, and therefore the position of Teacher or Professor is “permanent” in a way that Landscape Gardener cannot be.

How does this definition of “permanent” apply to Medical Trainees? The periods of mandatory and stipulated GME are set by the relevant American Board and rigorously enforced by the Accreditation Council of Graduate Medical Education (ACGME). Therefore, any Physician desiring to gain a recognized certification reflecting on professional competence in a recognized medical discipline needs to undertake a set, recognized course of medical training. So, how do the various levels of GME satisfy or not satisfy the requirement of “permanent” employment?

We consider Interns first. The typical PGY-1 internship year lasts exactly one year, generally from July 1–June 30 (although there are certainly instances of off-cycle GME). As contrasted to Landscape Gardeners, the position of Intern lasts fully one year. More importantly, the duties performed by Interns (diagnosing and treating

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122 E.g., In re Maimonides Medical Center, 93 INA 34 (BALCA 1994) (position of Resident in Psychiatry PGY-2); In re Presbyterian Medical Center of Philadelphia, 96 INA 61 (BALCA 1997) (position of Resident PGY II & III); In re Catholic Medical Center, 95 INA 547 (BALCA 1997) (position of Internal Medicine Physician (Resident)); In re Albert Einstein Medical Center (I), 96 INA 60 (BALCA 1998) (position of Resident PGY- II & III); In re Maricopa Medical Center, 97 INA 290 (BALCA 1998) (position of Internist, Resident); In re Albert Einstein Medical Center (II), 96 INA 0263 (BALCA 1999) (position of Medical Resident in Radiology PGY III and IV years). In all these cases, the Board of Alien Labor Certification Appeals (BALCA) has either not directly questioned the issue of permanence or ruled in the employer’s favor on that issue and has instead ruled on other grounds (in some cases for, others against certification).

123 In re Crawford & Sons, 2004 INA 121 (BALCA 2004).

124 Id. at 4, reaffirming In re Vito Volpe, 1991 INA 300 (BALCA 1993), at 5.

125 Id.

126 Id.

127 Id. See also Volpe, supra note 124, at 5 (“we hold that although these landscaping jobs may be considered ‘full time’ during 10 months of the year, and the need for these jobs occurs year after year, they cannot be considered permanent employment, as they are temporary jobs that are exclusively performed during the warmer growing seasons of the year, and from their nature, may not be continuous or carried on throughout the year”).

128 The Accreditation Council of Graduate Medical Education (ACGME) is responsible for accrediting post-MD courses of medical training in the United States, acting in conjunction with the relevant ABMS standards as well as the associated Residency Review Committees (RRC) within each academic training institution. www.acgme.org.
patients, albeit under close supervision) may be, and are, accomplished on a year-round basis. Arguably, then, even the position of Intern can be “permanent” enough to support a labor certification.

The case for Residents and Fellows meeting the standards for “permanent” employment is stronger. The position of Resident lasts, in most instances, at least two years (PGY-2 & 3 is a common designation for Residents) and Fellowships invariably last a year and, in most instances, for several years. The duties of Residents and Fellows undoubtedly can and are performed year-round, with the duties becoming more complex and independent with each passing year. While the jobs of Resident and Fellow are not indefinite, they satisfy the Crawford test as being “permanent” employment, despite the fact that Residency and Fellowship can be characterized as training.

This conclusion, although supported by BALCA case law, is now the subject of ongoing litigation within both the DOL and USCIS appellate review processes.

Until recently, various BALCA cases involving Intern and Resident positions either assumed that the positions offered were “permanent” enough to be the subject of a labor certification, or having resolved the permanence issue in favor of the employer and alien, were decided on other issues. However, beginning in 2008, the DOL started to question whether GME positions met the required standard of “permanence” so as to support a labor certification application. At roughly the same time, USCIS began to reexamine its position on the suitability of Trainee positions when adjudicating Second Preference I-140 petitions.

The challenge from USCIS initially arose when the AAO reviewed a rather unexpected series of denials of I-140 petitions based on degree equivalency. Here, USCIS, unilaterally and without warning, began to deny petitions filed on behalf of physicians who held 5-year foreign Bachelor of Medicine & Bachelor of Surgery (MBBS) degrees, which are the medical degrees issued in India, Pakistan, the United Kingdom and many other countries. The MBBS degree had always been deemed the equivalent of an advanced degree and, more specifically, the equivalent of a U.S. Doctor of Medicine (M.D.) degree. The ensuing outrage from the foreign medical community, especially from the academic community, where the Chairmen of major departments and even Deans of medical schools held such degrees, was palpable and the AAO beat a hasty retreat, finding in at least two unpublished decisions that such degrees were, indeed, the equivalent of U.S. Doctor of Medicine (M.D.) degrees. Moreover, USCIS later, pursuant to a memorandum, acknowledged that the U.S. is one of only a few countries where medical school applicants are required to have obtained a bachelor’s degree for admission to medical school and recognized that a foreign degree, including the MBBS degree, can be used to establish eligibility for classification as an advanced degree professional if certain conditions are met.

Although the MBBS degree equivalency issue ultimately was resolved in favor of the medical community, the issue of permanence also appeared on the radar screen. Indeed, the AAO was the first to question the issue of permanence while reviewing the case of a Senior Medical Resident where the sole issue before them—or so counsel thought—was the MBBS equivalency issue. The fact that the AAO, sua sponte, raised this new issue of permanence was a bit puzzling as the DOL had certified the underlying labor certification application without raising the issue of permanence at any stage in the process. In fact, at that time, the DOL continued to certify labor certification applications filed on behalf of Residents. Undaunted, the AAO issued an unpublished Notice of Intent to Invalidate the underlying labor certification application, chillingly basing its authority to do so on the assertion that the Employer had “misrepresented” the nature of the job opportunity to the DOL.

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129 Supra note 5.

130 Matter of [name not provided], SRC 08 198 51124 (AAO Jan. 9, 2009), Matter of [name not provided], SRC 08 219 53365 (AAO Jan. 29, 2009).


132 In its Notice, the AAO stated: “[A]s the job of senior medical resident in a ‘categorical three-year medical residency’ is not a permanent position, and it does not appear that the beneficiary is even qualified for a
was pending at the AAO, the DOL decided to enter the discordant symphony, issuing its very own message regarding the definition of “permanent” in the form of a Notice of Intent to Revoke the underlying labor certification application in the very case pending before the AAO. In order to do so the DOL claimed that its previously approved labor certification was not justified because the position of Senior Medical Resident was for temporary, not permanent, employment. With this new development it began to appear that the old adage of “be careful what you wish for” was in play, for that which practitioners had always asked for—interagency communication between the DOL and USCIS—was finally occurring, albeit not in the manner in which the immigration bar anticipated (or appreciated).

Certainly, the DOL’s Notice of Intent to Revoke was both a foreshadowing and a wake-up call. At approximately the same time that it issued its first Notice of Intent to Revoke in the case pending before the AAO, the DOL itself began denying labor certification applications filed on behalf of Residents, echoing the positions of both the USCIS and AAO and stating, in unpublished decisions, that “[b]ecause such a [medical residency] program is finite in nature, the aforementioned medical residency training, in and of itself, is not permanent, but rather temporary employment.”

In the aftermath of these DOL determinations, employers responded in different procedural manners: some filed Motions to Reopen and Reconsider with the DOL, whereas others filed direct Requests for Board of Alien Labor Certification Appeals (BALCA) Review of these denials. Although many of these appeals are still pending today, BALCA has rendered several decisions on this issue.

Specifically, on November 17, 2010, BALCA issued an Order Granting the Certifying Officer’s Motion to Strike and Directing Parties to Confer and Advise.133 The Board, after granting sua sponte en banc review of two sets of appeals involving whether the position of Resident qualifies for permanent labor certification, granted the CO’s motion to strike all of the documentation submitted by the Employers in support of their appeals because such briefs and documentation were not in the record upon which the labor certification denials were based. Therefore, without a fully developed record, the Board found that en banc review had been “improvidently granted.”134 Moreover, the Board directed the parties to confer “to consider whether it is mutually beneficial to the parties to have the case reviewed on the merits based on full consideration of all argument and documentation presented to the Board, even if it was not technically part of the record upon which the CO denied certification” or, if not possible, that the Employers “consider whether they would wish to withdraw their requests for BALCA review in order for the cases to be remanded to the CO for consideration.”135

permanent position in his profession because he holds a temporary license as a graduate medical trainee, it appears that you misrepresented the nature of the job opportunity to the [DOL]. Thus, we intend to invalidate the alien employment certification pursuant to 20 C.F.R. §656.30(d).” Although the AAO later backed off from this position, such a strong accusation was a clear and troubling indication that the agency would not look favorably at similar cases in the future.

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133 In the Matters of Albert Einstein Medical Center and Abington Memorial Hospital, BALCA Order Granting Certifying Officer’s Motion to Strike and Directing Parties to Confer and Advise (Nov. 17, 2010), published on AILA InfoNet Doc. No. 10113061 (posted Nov. 30, 2010).

134 Id at 3.

135 Id at 7.
Once an agreement was reached, the parties were to advise the Board on how to proceed towards final disposition of these matters.\textsuperscript{136}

On November 21, 2011, BALCA, after denying the parties’ Joint Motion for Stay of Due Date for Recommendation of How to Proceed, concluded that there was a sufficient record to issue an en banc decision on the legal issue of the meaning of “permanent” employment under the PERM regulations.\textsuperscript{137} In its decision, the Board found that medical residencies are generally limited in time and, thus, not permanent for purposes of seeking permanent labor certification.\textsuperscript{138} However, the Board remanded the case to the Certifying Officer to afford the employers an opportunity to demonstrate that each job fits the definition of permanent as detailed in the opinion.\textsuperscript{139}

In 2011, while these DOL cases remained pending before BALCA, albeit in different litigation postures, unpublished Notices of Intent to Deny were issued in at least two of the 2008 still pending appeals before the AAO. Such Notices are instructive as to the manner in which applications for labor certifications filed on behalf of Medical Residents are currently being viewed. In these cases (which, it is important to stress, had been pending before the AAO for over 2 years), the AAO’s unpublished Notices stated that “evidence ha[d] come to light that the petition[s] may be moot” and that it intended to dismiss the appeals because the offered position of Senior Medical Resident did not constitute an offer of permanent employment.

The evidence of such mootness\textsuperscript{140} referenced in the AAO Notices came about in an interesting manner: The AAO turned to various internet sites to determine that the Medical Residents in question had already completed their residency training and were employed as physicians with other employers, in other states, including in subspecialties that were different or more specialized than the medical discipline that appeared in the labor certification included with the I-140 petitions. Specifically, the AAO accessed, inter alia, websites from the Accreditation Council for Graduate Medical Education (ACGME), residency programs, the American Board of Internal Medicine (to verify board certification) as well as licensure records of states other than the original states in which the Medical Residents had held licensure at the time their appeals were first filed. In addition, they accessed USCIS records and commented that one of the two Medical Residents in question had already been issued conditional permanent resident status based upon his marriage to a U.S. citizen. Most importantly, however, the AAO noted that, in order for the I-140 petition to be approved, “the petitioner must maintain a continuing intent to permanently employ the beneficiary in the offered position…. Where no legitimate job offer exists for the offered position, the request that a foreign worker be allowed to fill the offered position has

\textsuperscript{136} Id.

\textsuperscript{137} In the Matters of Albert Einstein Med. Ctr. and Abington Memorial Hospital, (BALCA, November 21, 2011) (en banc), published on AILA InfoNet Doc. No. 11112265 (posted Nov. 22, 2011).

\textsuperscript{138} Id.

\textsuperscript{139} Id.

\textsuperscript{140} The question of whether such appeal is moot will not be addressed here but is certainly one which practitioners who continue to litigate these cases will face at the AAO and perhaps federal court level.
become moot, and the petition must be denied.” The AAO further instructed that “[i]f the [petitioner] currently intends to permanently employ the beneficiary,” it should “provide an affidavit of an officer of the hospital confirming, under penalty of perjury, that this is the case” and also “explain how it is possible for an individual who has already completed an internal medicine residency and is board certified in internal medicine can serve as a Senior Medical Resident.” On the issue of permanence, the AAO acknowledged that while “the petitioner has a permanent need for the services provided by medical residents,” such need “is not sufficient to establish that the offered position is permanent for an employment-based immigrant visa petition.”

Clearly, the issue of “permanence” was one which USCIS felt needed to be redefined, for while some labor certification applications for Residents continued to be approved by the DOL even after its above-mentioned change in adjudicatory practice, USCIS raised a new roadblock at the I-140 stage, as expressed in its June 12, 2009 memorandum detailing its revisions to the Adjudicator’s Field Manual (AFM) regarding the adjudication of I-140 Petitions filed on behalf of physicians. This memo discusses whether a foreign medical degree is equivalent to a U.S. medical degree and, thus whether such degree should be considered an advanced degree for purposes of EB-2 classification. In addition to requiring evidence to establish that the beneficiary holds a degree that is equivalent to a U.S. medical degree, the memo suggests that the beneficiary must also qualify for full and unrestricted (i.e. “permanent”) medical licensure in the state of intended employment, which is something the majority of states will not grant until the completion of a full three years of a residency program. Ironically and assumedly not intentionally, in an effort to foreclose the ability of Medical Residents to pursue Lawful Permanent Resident status while still engaged in Graduate Medical Education training, this USCIS memo created an unfair advantage for Medical Residents who choose GME programs in those states which grant permanent licensure after two years of residency.

Thus, while those law firms involved in the appeals surrounding the issue of pursuing lawful permanent resident status on behalf of Residents continue to stress that the BALCA holdings in Crawford and its predecessor case, Vito Volpe, are correct and should be upheld, that belief, given the currents emanating from DOL, USCIS and the AAO, should be tempered with an understanding that this issue is far from settled. Attorneys who wade into these muddy waters should be cautioned to make sure that their clients fully understand the uncertainty of this field and that, wherever possible, counsel any foreign physician involved in this process to maintain a valid underlying H-1B status throughout.

Considerations for Immigrant Visa Number Availability

Having established that, as a threshold matter, Medical Trainee positions, should the pending litigation prevail, may ultimately support a permanent labor certification and that those who choose to proceed down this path should do so with great caution, we now turn to several practical considerations of actually structuring a labor certification for a Medical Trainee. Before doing so, however, it is imperative to discuss the timely and major issue of unavailability of immigrant visa numbers. This is because prior to embarking on a labor certification for a Medical Trainee, both the practitioner and the clients must understand that, even if a labor certification and I-140 immigrant petition are ultimately approved for a Medical Trainee, there is a substantial

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141 AAO Notice of Derogatory Information, Request for Evidence and Notice of Intent to Deny, SRC SRC 08 185 51111 (Feb. 22, 2011).

142 Id.

143 Id.

144 Supra note 14.

possibility that the alien will not be holding the position by the time that permanent resident status is granted. Indeed, the alien physician likely will not be holding the trainee position described in the labor certification even by the time that an Adjustment of Status application (Form I-485) may be filed (or, analogously, certainly not by the time an immigrant visa could be issued overseas).

There are multiple reasons for this reality, including: the time required to properly prepare and recruit for a PERM case; delays in the PERM and I-140 processing times at DOL and USCIS; and backlogs in the immigrant visa preference categories. Given that immigrant visa number availability hinges on country of birth, physicians from India and China face very long waits for the availability of an immigrant visa number in the employment-based second preference (EB-2) category, and there is certainly a plausible expectation that backlogs will also develop in the worldwide EB-2 numbers. Realistically, most one-year internships will be completed before an I-485 can be filed, even if the alien is not chargeable to India or China. For labor certifications for the position of Resident PGY-2+ and Fellows, it may be possible, but certainly not guaranteed, that the I-485 will be filed while the alien Physician beneficiary is working in the underlying GME position.

To file an I-140 petition, an employer’s intent to ultimately employ the alien in the offered permanent position must at least exist at the time of I-140 filing. Filing an I-140 petition when it is clear the employer has no intention to ever employ the alien is fraudulent and clearly barred by the Immigration and Nationality Act (INA). However, employment relationships and employers’ intent can change over time. The question then becomes whether an I-140 that is still pending (at the end of the Internship or Residency or Fellowship for which labor certification is sought) may and should still be approved after the physician has moved on to the next position or employer.

In the past, USCIS had stated that the employer’s future intent must still exist at the time the I-140 is approved. However, more recently USCIS has reversed its position and affirmed that at least in some situations

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146 For a variety of reasons, India is by far the largest single provider of International Medical Graduates (IMGs) to the United States, currently accounting for roughly 4.9 percent of Physicians now in practice in the United States. Fitzhugh Mullan, “Doctors for the World: Indian Physician Emigration,” 25 Health Affairs No. 2, at 380–93 (2006).

147 For Indian and Chinese physicians, cross-chargeability to a derivative spouse’s different country of birth is possible (see 9 Foreign Affairs Manual (FAM) 40.1 N8), though in reality the number of instances of cross-chargeability is small.

148 Section 204(a)(1)(F) of the Immigration and Nationality Act (INA) states that, “Any employer desiring and intending to employ within the United States an alien entitled to classification under section 1153(b)(1)(B), 1153(b)(1)(C), 1153(b)(2), or 1153(b)(3) of this title may file a petition with the Attorney General for such classification.”

149 INA §212(a)(6)(C)(i); Cf. 8 CFR §§292.3(b) and 1003.102(c), which make it a ground for being barred from practicing before the immigration service if an attorney “knowingly or with reckless disregard makes a false statement of material fact or law, or willfully misleads, misinforms, threatens, or deceives any person (including a party to a case or an officer or employee of the Department of Justice), concerning any material and relevant matter relating to a case.”

150 See U.S. Citizenship and Immigration Services (USCIS) Memorandum, “Continuing Validity of Form I-140 Petition in Accordance with Section 106(c) of the American Competitiveness in the 21st Century Act (AC21),” published on AILA InfoNet at Doc. No. 03081114 (posted Aug. 11, 2003) (“In all cases, an offer of employment must have been bona fide, and the employer must have had the intent, at the time the Form I-140 was approved, to employ the beneficiary upon adjustment.”); see also USCIS Headquarters Response to Issues Raised by AILA at the AILA/USCIS Benefits Liaison Meeting On Oct. 1, 2003, published on AILA InfoNet at Doc. No
the I-140 should not be denied even if it comes to the attention of USCIS, in the course of adjudicating the I-140, that the alien has left the employer. Specifically in “portability” cases under INA §204(j) (discussed in further detail below), USCIS has instructed adjudicators that an I-140 should be approved even if it has come to USCIS’s attention that the alien no longer is employed by the I-140 petitioner. This principle is not limited to portability cases—if the alien physician has to cease working in a particular stage of medical training in order to move on to the next position, it makes as much sense that a pending I-140 should still be approved (even if no I-485 has been filed) as in the portability situation. The key fact is that back at the time of I-140 filing both employer and employee had the correct intent. If the granting of permanent resident status could occur instantaneously the day after I-140 filing, the intent to employ the alien physician in the Medical Trainee position would clearly be shown by the alien returning to work the next day in the same Trainee position. By the alien physician having actually worked the full year or more in the Trainee position described in the labor certification and I-140, it is clear that at the time of I-140 filing during that year the employer and alien both had the intent that the alien fill the position permanently. That the processing time for labor certifications, I-140 petitions, and I-485 applications and waiting times for cut-off dates to move on the Visa Bulletin make it impossible to predict exactly when the alien will get permanent residence, those unpredictable times do not change the fact that the employer and alien clearly had the necessary intent at the time of I-140 filing, when the alien has in fact worked in the Trainee position and completed it successfully. It is the authors’ position that as long as the I-140 petition is pending at the time of I-140 filing, the intent to employ the alien physician in the Medical Trainee position instantaneously the day after I-140 filing, the intent to employ the alien physician in the Medical Trainee position can be shown. Thus, an I-140 for a former position need not be withdrawn; legacy Immigration and Naturalization Service (INS) guidance confirms that an employer is under no obligation to request withdrawal of the position’s normal duration, the pending I-140 remains valid even if approved after the physician has moved on to the next position. An approved I-140 for a former position need not be withdrawn; legacy Immigration and Naturalization Service (INS) guidance confirms that an employer is under no obligation to request withdrawal of an I-140 that has filed for an alien if its intent changes subsequent to filing.

If an I-485 cannot be filed (or immigrant visa obtained) prior to completion of the year(s) of the Medical Trainee position which formed the subject of the labor certification application, then the alien should be prepared

03112547 (posted Nov. 25, 2003) (“The petitioning employer must have the requisite future intent throughout the pendency of the petition/application. Thus, the employer/petitioner on the petition at the time of approval must have had the requisite intent.”).


552 As one well-known immigration attorney would often say to the authors, “What is sauce for the goose is sauce for the gander.”

553 Indeed USCIS has repeatedly confirmed that the alien has no obligation to work for the sponsoring employer while the I-140 petition is pending. See USCIS Memorandum, supra note 151, at 4, Q&A 10. See also USCIS Memorandum, supra note 150, at 3 (“It should be noted that there is no requirement in statute or regulations that the beneficiary of a Form I-140 actually be in the underlying employment until permanent residence is authorized.”).

554 Legacy Immigration and Naturalization Service (INS) Letter from Thomas Simmons to Richard Steel (Oct. 20, 1999), published on AILA InfoNet at Doc. No. 00042507 (posted Apr. 25, 2000) (“While Service regulations at [8 CFR] section 205.1(a)(iii) outline the reasons for an automatic revocation of an employment-based immigrant petition, there is no specific requirement that the employer notify the Service.”). The termination of the employment relationship does not automatically revoke a pending or approved I-140 petition; compare 8 CFR §205.1(a)(iii).
for the prospect that he or she may at most gain an I-140 approval and “lock-in” a priority date that can later be retained as the priority date on a new I-140 based on a new labor certification filed by a future employer.\textsuperscript{155} In the case of Indian and Chinese EB-2 aliens, at the present time (and possibly all EB-2 aliens in the future, if a retrogression occurs in the worldwide EB-2 category), there is a realistic possibility that they will need to wait several years beyond I-140 filing or approval for their priority dates to be reached. Priority date cut-offs on the Visa Bulletin do not advance in steady fashion but instead tend to stay frozen and then make random jumps backward or forward at different times through a given fiscal year, as occurred in June–August 2007, and most recently with the severe backward movement of the India EB-2 cutoff on the January 2008 Visa Bulletin.\textsuperscript{156}

It is quite possible that, several years after locking in a priority date for an I-140 filed for the position of Medical Trainee, an alien will see his or her priority date be reached, long after the alien has moved on to a new position with a different employer. In this situation, which has already been common for the past two years and will remain common for years to come (absent an increase in the employment-based immigrant visa quotas), there is debate among practitioners as to whether an alien can file an I-485 in the future when the priority date is reached:

The “aggressive” position: In favor of filing the I-485 long after the Trainee position ended is the argument that \textit{back at the time when the I-140 was filed}, both the employer and alien had the required intent that the alien would fill the position if permanent residence were immediately granted on that date. It is only the accident of the alien’s birth and the per-country limits imposed by INA §202 that prevented the alien from concurrently filing an I-485 at the time of I-140 filing. Therefore the alien may file an I-485 without any new I-140 by the alien’s current employer.

The “conservative” position: Against the filing of the I-485 long after the position ended is the argument that the filing of an I-485 based upon a pending or approved I-140 is a statement of the alien’s \textit{present} intent (intent on the date of I-485 filing) to work for the I-140 petitioner in the future at the time the I-485 is approved. Since the alien clearly will not be going back to being an Intern or Resident or Fellow and the alien is already working full-time as a physician, to file an I-485 now based only on the approved I-140 from back in the physician’s internship/residency/fellowship days would be fraudulent conduct and the alien risks becoming deportable.\textsuperscript{157}

The aggressive position is questionable and concerning, and the debate can be mooted if the physician can be sponsored for a new labor certification at his or her new post-residency or post-fellowship employment. To avoid putting too many eggs in one basket, the physician who completes the several years of training and emerges with an approved I-140 but no pending I-485 should seek to be sponsored on a new labor certification at a post-GME job. The physician can then invoke the priority-date retention provision, 8 CFR §204.5(e), when the new employer files the new I-140 petition. It goes without saying that if a physician filed an I-485 taking the “aggressive” position argued above, he or she should maintain H-1B status at all times the I-485 is pending and not switch to using an employment authorization document (EAD), in the event of I-485 denial on grounds that the I-485 could not be filed because the alien no longer intended to work for the I-140 petitioner on the date of I-485 filing.

\textsuperscript{155} The priority date accorded by an \textit{approved} I-140 in the EB-1, EB-2 or EB-3 categories can be retained by the alien on any subsequently approved I-140 that is also in the EB-1, EB-2 or EB-3 categories. 8 CFR §204.5(e).

\textsuperscript{156} Current and archived Visa Bulletins are available on the DOS Consular Affairs website at: \texttt{http://travel.state.gov/visa/frvi/bulletin/bulletin\_1360.html} or through AILA InfoNet at: Agencies Liaison \rightarrow Department of State \rightarrow Visa Bulletins.

\textsuperscript{157} \textit{Supra} note 32.
Applicability of Portability Rule if I-485 is filed

If the timing works out such that the Physician is able to file the I-485 while still in the GME position, but then moves on to a post-GME position of Practicing Physician before the I-485 is approved, it becomes necessary to analyze whether the I-485 will be approved under the “portability” rule. In its essence, this rule states that as long as the I-140 petition has been approved and more than 180 days have passed since I-485 filing, the adjustment application remains approvable even though the applicant no longer intends to work for the I-140 petitioner but instead has moved to new employment in a “same or similar” occupational classification. USCIS guidance directs adjudicators to compare the job duties of the two positions, as well as the applicable Standard Occupational Classification (SOC) codes and the difference in salary. It is generally true that Physicians experience a considerable increase in salary upon completion of GME; however, this is only one factor and practitioners should emphasize to USCIS that the similarity of the job duties is more important than any salary discrepancy. The SOC code category 29-1060 for Physicians and Surgeons includes all categories of physicians with no distinction placed between physicians engaged in GME and those that have completed their GME. That is a strong factor in favor of finding that post-GME positions are sufficiently “same or similar” to GME positions. In the end, the Physician’s core duties both during GME and afterwards will consist of diagnosing and treating illness and thus should arguably support I-485 approval under the portability rule. Nonetheless, caution mandates that any Physician in H-1B status who has filed an I-485 application and who will rely on the portability rule be advised to maintain H-1B status at all times independent of the I-485 application since determinations on the applicability of the portability rule are made only at the very end of the I-485 case. As noted above, it is equally true that a good back-up plan is to have the new employer file a new labor certification case as well. If a new labor certification is approved and the previous priority date retained on the new employer’s I-140, there is longstanding USCIS guidance pre-dating the portability rule that allows the pending I-485 to be transferred to the new I-140 petition.

Actual Minimum Requirements—Practical Considerations

Any enthusiasm for sponsoring a Medical Trainee for a permanent labor certification must be tempered with the realization that it is not a simple business to define the actual minimum requirements for the position accurately while still ensuring success at the I-140 stage if the labor certification is approved. The actual minimum requirements might not be ones the alien physician can satisfy while still keeping consistent with Department of State (DOS) and USCIS regulations and case law.

The educational requirement of an MD degree (plus the requirement for authorization to perform the position whether through a full state medical license or through limited licensure) generally should not present a problem since these are not credentials obtained through employment at the sponsoring employer. The difficulty arises when considering the required work experience, captured in Sections H6 and H10 of the Form ETA Form 9089 application. The DOL regulations require that the position requirements stated in Section H of the ETA Form

158 INA §204(j).


160 www.bls.gov/soc/soc_j1g0.htm.

161 See INS Memorandum, “Transferring Section 245 Adjustment Applications to New or Subsequent Family or Employment-Based Immigrant Visa Petitions,” published on AILA InfoNet at Doc. No. 00062110 (posted June 21, 2000).

162 The references to particular boxes of the ETA Form 9089 made in this article conform to the current version in effect at the time of writing, which was implemented in 2009 and expires on August 31, 2014. In revising the form in 2009, the Department of Labor (DOL) added one question worth noting. Specifically, new question J21
9089 “must be those normally required for the occupation[.]” In the GME context, this rule can lead to a direct clash with the rule that:

If the alien beneficiary already is employed by the employer, in considering whether the job requirements represent the employer’s actual minimums, DOL will review the training and experience possessed by the alien beneficiary at the time of hiring by the employer, including as a contract employee. The employer cannot require domestic worker applicants to possess training and/or experience beyond what the alien possessed at the time of hire unless:

(i) The alien gained the experience while working for the employer, including as a contract employee, in a position not substantially comparable to the position for which certification is being sought, or

(ii) The employer can demonstrate that it is no longer feasible to train a worker to qualify for the position.

We will consider the impact of these two competing rules in the cases of Interns, Residents and Fellows in order.

For the position of Intern, it is not customary to require work experience since the position of Intern is the first post-MD work experience the physician gains. Therefore a labor certification for an Intern that contains no experience requirement in Sections H6 or H10 should not run afoul of the prohibition against counting experience gained at the same employer.

The position of Resident presents considerably more difficulty by comparison. A GME program cannot admit a physician to the position of Resident (PGY-2 and beyond) if the physician does not have at least one year of experience as an Intern. Therefore, it is expected that Section H of the ETA Form 9089 will reflect a requirement of at least one year of the same or related work experience as an Intern. But nearly all Residents have completed their Internship year at the same employer, thus prohibiting them from counting their Internship year toward satisfying the experience requirement of a labor certification for the position of Resident with that same employer.

As quoted above, the prohibition in 20 CFR §656.17(i)(3) does contain two exceptions that an employer may claim in an audit if a Resident’s qualifying year of work experience as an Intern was gained at the same employer. Considering these exceptions in reverse order, if the employer continues to train Interns who are one year behind the current class of Residents that includes a sponsored alien, arguably it is feasible for the employer to train a worker for the position of Resident (and thus undercutting the second exemption from the prohibition against counting Internship experience at the same employer).

This leaves the first exemption, which allows the sponsored foreign national employee to count the Internship year as qualifying work experience toward the position of Resident if the position of Intern is “not substantially comparable to the position [of Resident] for which certification is being sought.” This first exemption is the one more likely to succeed. The DOL regulations define a “substantially comparable job or position … [as] a job or position requiring performance of the same job duties more than 50 percent of the time. This requirement can be

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163 See 20 CFR §656.17(i)(3).

164 See note 1625, supra.
documented by furnishing position descriptions, the percentage of time spent on the various duties, organization charts, and payroll records.\textsuperscript{166}

To count the alien physician’s Internship year as qualifying experience that may satisfy Sections H6 and H10 on the ETA Form 9089\textsuperscript{167} therefore requires distinguishing the job duties of Intern and Resident as being more than 50 percent different. Prior to the PERM regulations, the Delitzer test was applied to this situation to determine whether or not experience gained at the same employer could be counted towards the labor certification (whether or not the prior positions were “sufficiently dissimilar” as compared to the current standard of “not substantially comparable”).\textsuperscript{168} The implementation of PERM replaced Delitzer’s multi-factor test with the 50-percent rule.\textsuperscript{169} Though BALCA case law\textsuperscript{170} on this issue pre-dates the implementation of the PERM regulations, it is still highly informative due to the similarity of the Delitzer test to the 50-percent rule. In two cases, BALCA found that the positions of Intern and Resident were not sufficiently dissimilar and that the positions lie on a continuum with no significant change in the duties (other than augmented responsibilities) from Intern to Resident. Therefore certification was denied because the requirement of a year of PGY-1 experience was deemed inappropriate because the sponsored physicians gained their PGY-1 experience at the same employer.\textsuperscript{171}

However, at least one subsequent BALCA case did successfully distinguish these two earlier decisions and found that the position of Resident PGY-2 \& 3 was sufficiently dissimilar from the position of PGY-1 such that requiring PGY-1 experience was in fact an actual minimum requirement even though all the sponsored alien physicians gained their PGY-1 experience at the same employer.\textsuperscript{172} Characterizing the two previous holdings as a failing of the employers in those cases to sufficiently document the differences between the PGY-1 and later post

\textsuperscript{166} 20 CFR §656.17(i)(5)(ii).

\textsuperscript{167} See note 162, supra.

\textsuperscript{168} See Albert Einstein Medical Center (I), supra note 122, at 3, citing Brent-Wood Products Inc., 88 INA 259 (BALCA 1989) (en banc); The Cinnamon Buns Inc., 93 INA 99 (BALCA 1994), and enumerating the various factors to be considered when comparing the two positions, as provided in Delitzer Corp. of Newton, 88 INA 482 (BALCA 1990) (en banc).

\textsuperscript{169} In the Supplementary Information to the PERM regulation, DOL agreed with the majority of commenters that there are legitimate situations where experience gained with the same employer in a different position should be allowed to count towards the experience requirement for the position for which certification is sought, but found that “the specific Delitzer criteria are unnecessarily complex and, in practice, difficult to administer.” See 69 Fed. Reg. 77326, 77354 (Dec. 27, 2004).

\textsuperscript{170} See note 122 supra.

\textsuperscript{171} See Maimonides Medical Center, supra note 122, at 4 (position of Resident in Psychiatry PGY-2 required one year of PGY-1-level experience; held “in reality a residency is in fact one job, and was acknowledged by Employer, as such the progression of a psychiatric residency through the various levels of a residency to the staff psychiatrist position is essentially on a continuum with augmented responsibilities throughout but with no significant change in the essential duties.”); Presbyterian Medical Center, supra note 122, at 5, (position of Resident PGY-2 \& 3 required one year of experience in the job offered or related occupation of PGY-1; held following Maimonides that the positions of PGY-2 \& 3 are on a continuum with PGY-1 and not sufficiently dissimilar; thus it did not reflect the employer’s actual minimum requirements to require PGY-1 experience when the alien gained the PGY-1 experience with the same employer).

\textsuperscript{172} See Albert Einstein Medical Center (I), supra note 122, at 5.
graduate years, the decision in *Albert Einstein Medical Center* emphasized that the employer had, indeed, documented the different supervisory, teaching, and staff interaction responsibilities of Residents versus Interns in satisfaction of the regulations.\(^\text{173}\) The *Albert Einstein Medical Center* decision provides guideposts for the evidence that practitioners should gather to address this issue in the planning stages of the case since an audit is more likely to be triggered.

As for the position of Fellows, the same issue arises as with Residents if the PGY-2-and-beyond experience required for the Fellowship is gained at the same employer. If a foreign physician does a Fellowship at a different employer than his or her Residency training, this issue does not arise.

**Why and Under What Conditions would a Labor Certification Application be Filed for a Medical Trainee?**

The next question we consider is what factors would lead an academic institution to file a labor certification application for a Medical Trainee. After all, when all is said and done, a labor certification requires the active commitment and involvement of the employer, and the Physician will not remain employed for a lengthy period of time by the academic institution (unless the intention is to hire the Physician upon completion of the period of GME). The temporariness of a foreign physician’s period of GME employment may temper an academic institution’s willingness to undertake the complex and expensive labor certification process. This is particularly true given the DOL rule requiring that all attorney’s fees and recruitment costs for the labor certification stage of a permanent residence case be paid by the employer without reimbursement by the employee.\(^\text{174}\)

The average Medical Trainee accounts for roughly $150,000 in billed revenues from Medicare per year,\(^\text{175}\) but draws a salary well below the compensation level of an Attending Physician. Particularly as Medicare reimbursement rates drop, there are increased pressures within many teaching hospitals to look to Medical Trainees as highly lucrative providers of clinical care to the indigent and medically underserved—mandates that potentially call into question the proper balance between clinical service and medical training.

Indeed, given the inability to attract U.S. citizens to enter medical residency programs, the ability to attract and keep IMGs becomes even more critical. The substantial reliance of the American medical system upon foreign Medical Residents is best captured in a yearly report published by the National Resident Matching Program (NRMP) entitled: “Results and Data 2011 Main Residency Match.”\(^\text{176}\) This report sets forth how many Resident slots remain unfilled and of those that are currently filled, how many would not be filled but for the availability of non-U.S. citizen IMGs. The alarming, representative data is as follows: Of 5121 residency positions in Internal Medicine, 1215 are filled by non-U.S. IMGs and 56 go unfilled; of 2708 residency positions in Family Medicine, 363 are filled by non-U.S. IMGs and 153 go unfilled; of 2482 residency positions in Pediatrics, 256 are filled by non-U.S. IMGs and 45 go unfilled; and of 1179 residency positions in Surgery, 129 are filled by non-U.S. IMGs and 444 go unfilled.\(^\text{177}\)

Regardless of how that question is resolved, however, the fact is that Medical Trainees are a key part of hospitals’ ability to treat patients. This is a factor in favor of persuading employers to make the commitment of effort and money to sponsor a Medical Trainee for a labor certification. However, hospitals/medical institutions

\(^{173}\) *Id.*


\(^{177}\) *Id.*
that proceed with the filing of labor certification applications for their Residents should do so with great caution and awareness of the risk involved, at least until the pending litigation is resolved.

Given the growing shortage of physicians\textsuperscript{178} and the role of many community-based teaching hospitals as primary providers of clinical services to medically vulnerable populations qualifying for lower reimbursement schedules, it has been our observation that various, largely inner city hospitals become much more receptive to provide permanent resident sponsorship (as well as H-1B status) precisely as a recruitment effort intended to attract IMGs to their programs.

It is perplexing, given the great shortage of physicians, especially in primary care, the aging U.S. patient population and the current administration’s legislation to expand access to health care to a larger segment of the population, that the DOL has chosen this particular time to challenge a previously accepted and common-sense method of ensuring access to health care by certifying labor certification applications for Medical Residents.

**General Issues for Physician Labor Certifications**

Having considered issues specific to labor certifications for Interns, Residents and Fellows, we now turn to issues of relevance to all labor certifications for Physicians in a variety of practice settings.

**Foreign Language Requirements—Business Necessity**

Owing to a variety of circumstances largely related to demographics of the patient populations served or the nature of the work environment, the actual minimum requirements of many physician positions include a foreign language. As is the case with any other labor certification, the inclusion of a foreign language requirement triggers the need for proof of business necessity that will justify the language requirement either as a function of the occupation or in light of the employer’s own specific needs.\textsuperscript{179}

The case law has struggled to distinguish between the inclusion of a foreign language requirement as an impermissible preference (with strong overtones of creating an unfair advantage to the foreign national beneficiary) as opposed to being a legitimate, job-related requirement for the position. To this end, the DOL has placed the burden squarely on the employer to not only quantify the extent to which a foreign language is required, but also to establish the absence of appropriate alternative methods that could be used to bridge any linguistic problems.\textsuperscript{180}

There are two developments within PERM that seemingly liberalize the acceptability of a foreign language in labor certification applications filed for Physicians: (1) the broadening of the business necessity standard that appears in the PERM regulations; and (2) the inherent need for clear, precise communication to patients and medical staff in a multi-lingual, multi-ethnic society as an unquestioned, absolute necessity to acceptable healthcare outcomes.\textsuperscript{181}

A foreign language may be a necessity to the position if required to communicate not only with outside customers and contractors, but also with the employer’s own workforce which, in this case, would be other


\textsuperscript{179} 20 CFR §656.17(h)(2).

\textsuperscript{180} Id.

medical personnel working with the physician.\textsuperscript{182} While physicians and various other allied health professionals are required to establish English language fluency as a precondition to state licensure (as well as immigration status, if required), there exists in medical practices a wide range of other important medical support personnel who may not be conversant in English (e.g., home care attendants, various medical technicians, etc.). Further, the Supplementary Information to the PERM regulations specifically cites safety considerations as being a major consideration in allowing a foreign language as a business necessity.\textsuperscript{183} We submit that the concepts of safety and health are quite closely related given that both deal with the essential welfare of individuals and that breaches to either safety or healthcare standards carry dire and, indeed, possibly fatal consequences. In this manner, there is already built in a greater allowance for foreign language given the Physician’s essential focus on health and safety outcomes for patients (as compared to, for example, a foreign language being an asset in marketing a luxury item to customers).

But beyond the provisions of the regulations, in our experience, there is a broad range of factors that have been recognized as justifying a foreign language for a position as a Physician, including:

- The location of a medical practice in an area having a high density of residents whose mother tongue is not English;
- The volume of non-English-speaking patients that the beneficiary of the labor certification application will be expected to treat;
- The absolute necessity of clear, direct communication with both patients and the entire medical team to achieve satisfactory healthcare outcomes;
- The reality that the level of communication needs to be not just at a colloquial level, but needs to extend to a technical level that oftentimes can be achieved only through direct communications in a language other than English between the physician-provider and the patient (this is a circumstance that many immigration attorneys can directly identify with from experience in attempting to communicate complex legal advice through a translator);
- The presence of large ethnic communities treated in the medical practice that lack English language fluency, and the need to communicate completely to patients not only during the actual encounter with the Physician, but also extending to an overall treatment program that could well include the involvement of other family members, home healthcare attendants, other healthcare providers, etc.;
- The wide socio-economic range of patients within various ethnic communities that makes it quite likely that a significant percentage of patients drawn from those communities will not be conversant with English;
- The inability in many medical practices—particularly those with walk-in practices—to predict the linguistic capabilities of patients;
- The unavailability and/or shortage of readily accessible, competent medical interpreters and a showing that even if such intermediaries were to be available, certain medical disciplines (e.g., emergency medicine) require split-second determinations and direct communication that would be compromised by communicating through third parties.

It is the authors’ experience that language requirements for physicians based on documenting factors such as these have been successful in obtaining certification after an audit in PERM cases.

\textbf{Academic Physicians—Special Recruitment Eligibility Provisions}

This section deals with the eligibility of Academic Physicians—particularly those holding university faculty appointments—to qualify under the Special Recruitment provisions (formerly called “Special Handling”).\textsuperscript{184} The
key issue relevant to physicians is whether the activities performed by Academic Physicians holding university faculty appointments may be considered as fulfilling the definition of “college or university teachers” for Special Recruitment purposes.

Academic Physicians unquestionably perform teaching/instructional duties, but unlike traditional classroom-based teachers, Academic Physicians teach by providing “on-the-job” instruction to students, Medical Trainees, and other allied health professionals on a daily basis. The teaching/instructional duties of these Academic Physicians are generally not performed in classroom settings, but rather as didactic clinical demonstrations that are performed in the wards in the presence and for the benefit of Trainees (defined as Medical Residents and Clinical Fellows) in fulfillment of the academic institution’s educational mandate. It would be absolutely impossible to provide medical education and training in fulfillment of ACGME standards without the hands-on clinical demonstration performed by medical faculty as a didactic activity.

Let’s take a closer look at the environment in which an academic physician works. The typical Academic Physician holds a faculty appointment that has been offered pursuant to the university’s faculty recruitment search procedures. Nobody denies that the Physician is performing direct clinical services in the treatment of patients just as a Physician in a non-academic setting would provide. But the clinical services by an Academic Physician are provided in a very special manner in that the services are intended to concurrently teach, train, and instruct physicians-in-training, and in fulfillment of the academic standards set by the ACGME as well as the relevant program curricula committees of the academic institution. In short, clinical service as a teaching/instructional modality is precisely how GME is conducted. The question is, does this hybrid situation of direct clinical services performed in an academic setting (as the standard method of providing GME) qualify the academic physician for Special Recruitment benefits?

The special provisions for university teachers appear at INA §212(a) (5) (A) (ii) (I). That section requires that “a member of the teaching profession” be “equally qualified … and available” as compared to any U.S. worker applicants for the teaching position, rather than having to meet the more rigorous standard of showing that the alien is the only minimally qualified and willing applicant for the position in order to be sponsored for labor certification.

The implementation of this statutory provision for members of the teaching profession appears in the DOL regulations at 20 CFR §656.18. These provisions establish a special procedure for college and university teachers that has two major benefits: (1) it allows a university’s previous faculty search recruitment process to satisfy the labor certification application requirements if the filing is made within 18 months of the final selection of the alien to the position; and (2) the requirement of the petitioning employer to establish that the foreign candidate is more qualified than any U.S. worker applicants for the position, even if a U.S. worker applicant might be “minimally” qualified in a regular labor certification case.

Neither the definitional section of the PERM regulations nor the above-cited regulation for Special Recruitment defines specifically what occupations or activities fall within the meaning of the term “college or

185 Each accredited institution maintains a Residency Review Committee (RRC) which is mandated to ensure that the institution’s program fulfills its purpose of providing medical education and training in a manner that will meet the standards set by various professional accreditation bodies.

186 It should be noted that under 20 CFR §656.18(d), even if a college or university is not able to able to claim Special Recruitment benefits due to failure to file the ETA Form 9089 within the 18-month window, the petitioning employer still has the option to show that the alien is more qualified than any other applicants for the teaching position pursuant to a regular labor certification recruitment conducted under §656.17. However, this option still is limited to college or university teachers, so the basic analysis as to what constitutes a “college or university teacher” under the “more qualified” standard also applies to the regular labor certification recruitment for medical school faculty.

187 20 CFR §656.3.
university teacher.” Rather, the delimiting requirement of “formal classroom-based teaching” only appears in two sources of the DOL’s literature: the Technical Assistance Guide (TAG) and a 1994 memorandum issued to the field.

The TAG requires “actual classroom teaching” in order to meet the definition of “college or university teacher” for Special Handling consideration. The apparent underlying policy here is to distinguish university teachers from other university non-teaching positions, such as researchers, librarians, or other administrative staff. This requirement of “actual classroom teaching” was also stated in a 1994 DOL memorandum from Barbara Ann Farmer to Certifying Officers.

If the TAG and the 1994 Memo had the full force of law, they would probably serve to exclude most medical school faculty from the Special Recruitment provisions. However, neither the TAG nor any guiding memoranda can contradict the statutory provisions, and there is also established precedent that limits the role of the TAG as being advisory to the Certifying Officers, but certainly not having the force of law. The TAG is an internally promulgated guide of the DOL intended to provide advisory guidance in the processing of labor certification applications. It has not gone through the rule-making or public comment provisions as required by the Administrative Procedures Act (APA) to have the force of law. This is not to say that the TAG has no relevance to agency action. But ultimately, the TAG is advisory rather than compulsory, and is not binding upon the DOL in its adjudication of labor certification applications. BALCA has repeatedly asserted that the TAG is not binding

Therefore, the practitioner, in cooperation with the employing institution, might well consider the circumstances under which a faculty physician could qualify for Special Recruitment benefits, despite the absence of formal classroom-based duties. Among the relevant factors would be:

1. Whether the academic/university institution has a clearly stated mandate of providing teaching and training services to medical students and trainees;
2. Reference to the position of the ACGME, the central evaluating and accrediting body for medical residency programs in the United States, which consistently refers to medical residency programs as education.
3. Whether the academic employer’s recruitment/advertising effort for university faculty refers to the position’s teaching and training obligations;
4. Whether the physician has been appointed to the position pursuant to the university’s established, normal faculty recruitment provisions for other non-medical faculty;
5. An understanding that medical school teaching is primarily done through didactic and clinical demonstration in that faculty members are performing clinical procedures as an instructional method to teach and train medical students, trainees, and staff, and that in the context of GME, this ward-based instructional-clinical method is the equivalent to classroom-based instruction in other academic disciplines (many of which in the sciences include a significant hands-on laboratory or internship experience);

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188 Technical Assistance Guide (TAG) Section I.D. (citing former 20 CFR §656.21a, the Special Handling Regulation that is substantially similar to present-day 20 CFR §656.18 on Special Recruitment).


190 See In re Polytex Fibers Corp. 87 INA 597 (BALCA 1989) (noting that “the TAG, not having been promulgated as a regulation, while perhaps advisory to COs [Certifying Officers], is neither persuasive nor binding on this Board”). See also In re Solectron Corp. 2003 INA 144 (BALCA Aug. 12, 2004).

6. Whether the physician faculty member is fully entitled to faculty privileges and faculty benefits, as well as whether the physician goes through certain University review policies that generally parallel the faculty appointments in more traditional, classroom-based academic disciplines.

These factors highlight academic situations that conform with the intent of Congress in promulgating INA §212(a)(5)(i)(I) and the intent of the DOL in implementing this statutory provision in the regulations on Special Recruitment, at 20 CFR §656.18, notwithstanding the pre-PERM guidance in the TAG and the Farmer memo seeking to limit this category to teaching positions involving actual classroom teaching.

**Timing of Labor Certification Application—Pre-Board Eligibility**

Early during their last year of GME, many foreign physicians-in-training are in the enviable position of having an offer of employment to start immediately after their residency (subject to their completing their GME so as to gain Board eligibility). Some of these physicians also have the support of their prospective employers with regard to the filing of a labor certification application prior to the commencement of employment. A foreign worker does not need to be working for an employer as a nonimmigrant before the employer can begin the permanent residence process, even if the more common scenario is to hire a foreign worker as a nonimmigrant before starting the labor certification process.

There are various reasons to start the labor certification process as soon as possible. With the severe retrogressions in the EB-2 categories for Indian and Chinese physicians and the specter of potential world-wide EB-2 retrogression, getting a priority date as early as possible is highly desirable for any foreign worker seeking to become a permanent resident. Even more important, in many instances, a foreign physician who was not sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG) for J-1 status will have used up several years of H-1B status during the period of GME and thus have an even more urgent need to be sponsored for permanent residence so as to become eligible for extensions of H-1B status beyond the six-year limit. The basic track for most primary care medical disciplines runs at least three years, and supplementary periods of specialized and sub-specialized training can take additional years that easily can reach or exceed the six-year limit of H-1B eligibility. Thus, for many physicians using H-1B status to complete their GME there is strong pressure to prepare and file a labor certification even before the alien physician has completed the required period of GME.

The desire to lock-in the earliest possible priority date and/or to qualify for extensions of H-1B status beyond the six-year limit must be tempered with the need to ensure that a foreign worker is qualified for the position as of the date of establishment of the priority date. This requirement does not come from the DOL regulations, which actually do not always require the alien worker to be fully qualified for the position offered as of the date of labor certification filing. Rather, the requirement to be fully qualified as of the date of labor certification filing comes from the INA and USCIS regulations, as interpreted in long-standing agency precedent decisions and recently reaffirmed by USCIS.

In the decision in *Wing’s Tea House*, the Acting Regional Commissioner denied an immigrant worker petition because the foreign worker gained the required work experience only after the labor certification had been filed.

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192 See supra note 1536.

193 See generally, §§ 104(c) and 106(a) of The American Competitiveness in the Twenty First Century Act (P.L. 106-313).

194 20 CFR §656.17(i)(3) only limits an employer to requiring experience that the alien possessed prior to hire if the alien is already working for the employer in the offered position. If a labor certification is being prepared and filed by an employer who has not yet hired the foreign physician (and will not hire the physician until the required period of GME is completed, usually the following summer), the prohibition in 20 CFR §656.1(i)(3) simply does not apply.
with the DOL, thereby establishing the case’s priority date. USCIS reaffirmed this holding in a September 23, 2005 memorandum which states that USCIS “cannot approve [an I-140] petition for a preference classification if the beneficiary was not fully qualified for the preference [classification] by the priority date [established by the filing] of the labor certification.”

The question for this discussion is how these principles apply to a labor certification being prepared by a prospective employer for an alien physician who has not yet completed the required or desired period of GME. In nearly all instances, being Board Certified or Board Eligible (commonly abbreviated as “BC/BE”) is an absolute requirement for the position as well as a commonly recognized professional certification standard for the practice of medicine. Yet, if the labor certification application is indeed filed during the final year of GME, the Physician will not have obtained Board Eligibility by the time of filing.

So how do these competing realities translate into the actual drafting of the labor certification application? In our opinion, there are two alternatives.

One approach is to state the need for Board Eligibility as of a future date-certain. Owing to the stipulated and uniform periods of required GME set by the ACGME, it is possible to define precisely when a physician-in-training will become Board Eligible. Generally, the date is the conclusion of the normal academic year of June 30, although there are certainly many instances of off-cycle training. Regardless, it is possible for a particular physician near the end of GME to precisely identify the date for gaining American Board Eligibility.

As such, under this approach, the practitioner would draft the ETA Form 9089 to state that Board Eligibility needs to occur effective on the alien beneficiary’s last day of training, which will virtually always precede the alien’s first day of work at the sponsoring employer. Under logic reminiscent of T.H. White, the statement of a requirement set in the future would arguably mean that the alien possesses the stated, existing requirements at the time of filing—the alien is not claiming to be Board Eligible at this moment while still in the threshold issue, care should be taken to determine whether the alien physician may satisfy Board-Eligibility criteria based on periods of training taken abroad. In some instances, although fairly rarely encountered, foreign work experience may be counted by the American Board of Internal Medicine as counting toward eligibility to sit for the board exam. See www.abim.org/certification/policies/special.aspx.


As a threshold issue, care should be taken to determine whether the alien physician may satisfy Board-Eligibility criteria based on periods of training taken abroad. In some instances, although fairly rarely encountered, foreign work experience may be counted by the American Board of Internal Medicine as counting toward eligibility to sit for the board exam. See www.abim.org/certification/policies/special.aspx.

See supra note 162.

In The Once and Future King, the character of Merlin moves backward in time, therefore having illimitable prescience and foresight, although slithering at cross-purposes to the course of normal human events—a situation quite appropriate to current immigration legal practice.
midst of GME, but rather is acting in a manner logically intended to achieve Board Eligibility by the stated future date while meeting in its entirely all of the requirements existing as of the date of filing. The authors are aware of a number of approved labor certification applications and I-140 petitions based on requirements stated as a condition scheduled to occur in the future.

A second (and in our opinion more solid) approach is simply to state in quantifiable terms the period of the alien’s GME training. For specialty care positions, this would take the form of BC/BE in a primary care medical discipline supplemented by a stated, quantifiable period of advanced training. For positions in primary care medicine, the stated requirement would be limited to the period of GME accomplished by the foreign physician at the time the labor certification is filed.

Are these the actual minimum requirements for the position as required by law? We think that the answer is clearly “yes.” Arguably, they are not the full requirements of the position, since Board Eligibility is required but for the reasons appearing above, it may not be possible to include that requirement in drafting the labor certification application. But in essence, any Physician—U.S. or foreign—who completes stipulated periods of GME will have completed the essential sequence of requirements for Board-Eligibility purposes. In short, the omission of the requirement of Board Eligibility does not unwise or unethically open up the requirements of the position to candidates who fail to gain Board Eligibility.200

“Foreign-Equivalent” Medical Degree201

One critical issue which arises in foreign physician labor certification and which requires comment is the potential for I-140 denial (after the labor certification stage) for foreign physicians who have earned a medical degree abroad if such degree is not considered to be an advanced degree meriting EB-2 classification. This issue most commonly arises with a Bachelor of Medicine and Bachelor of Surgery degree, commonly abbreviated MBBS.

For purposes of obtaining an ECFMG certificate, ECFMG considers an MBBS degree to be one of the acceptable credentials for medical school education, depending on the country in which the physician was educated.202 An ECFMG certificate does not explicitly confirm that a particular foreign degree is equivalent to an MD, or that the MBBS degree is an advanced degree, but in practice, the distinction between having earned an MBBS degree versus an MD degree has not prevented the foreign physician from obtaining employment, from

200 Cf. 20 CFR §656.17(h)(1), which requires that “the job opportunity’s requirements, unless adequately documented as arising from business necessity, must be those normally required for the occupation and must not exceed the Specific Vocational Preparation [SVP] level assigned to the occupation as shown in the O*NET Job Zones.” This prohibition is clearly designed only to prevent an employer from placing excessive requirements in Section H on the ETA Form 9089 in an attempt to unfairly eliminate potential U.S.-worker applicants for the position. This regulation does not conversely require employers to state possible requirements for the position that are not clearly required to be stated as education, training or work experience in Section H.

201 The authors wish to express their sincere thanks to attorney Jane Goldblum of Goldblum & Hess for her contribution to this section.

202 See ECFMG 2009 Information Booklet, p. 41 & Appendix 1 (listing by country the formal name(s) of what medical degrees ECFMG will consider to be a final medical diploma), available at http://www.ecfmg.org/2009ib/contents. html. For example, for numerous countries, including India & Pakistan, ECFMG lists MBBS degrees specifically. For China, ECFMG lists a Bachelor of Medicine in Medicine degree certificate. For Egypt, ECFMG lists MB ChB diplomas.
obtaining admission to a U.S. residency or fellowship program, or from obtaining state licensure. However, as mentioned above and beginning in 2008, decisions issuing from USCIS revealed that some adjudicators were denying EB-2 I-140 petitions on the basis that an alien physician beneficiary who holds an MBBS degree does not satisfy the petitioning employer’s requirement of an “advanced” degree. USCIS stated:

The petitioner may either show that the position listed on the labor certification requires an individual holding an advanced degree or that the position listed on the labor certification requires an individual holding the equivalent of an advanced degree. The equivalent of an advanced degree is a baccalaureate degree and five years of experience.

In the denied case in which this language appeared, the employer had indicated that any “medical degree” would satisfy the educational requirement, a statement that is well understood to refer to an MD degree, since an MD is the normal requirement for entry into the position of Physician in the United States. Since the beneficiary held an MBBS degree and did not have five years of progressive experience at the time of filing, USCIS concluded that the position “[could not] be determined to be an advanced degree position.” However, as discussed above, the AAO and USCIS returned to the sensible determination that an MBBS degree is an advanced degree, equivalent to an MD and qualifying the alien physician for EB-2 classification.

As always, practitioners should be vigilant in drafting the ETA Form 9098 application and obtain, when advisable, a credentials evaluation that concludes that the foreign physician’s credentials prove that he holds an advanced degree. The ETA Form 9089 permits any foreign-equivalent medical degree, assuming (as is likely) degree equivalents are accepted by the employer and the state medical licensing board. In the past, the authors of this article have specified “Other” as the minimum education requirement and “Medical Degree” as the required level of education, further indicating in Section H.9 that a foreign equivalent was acceptable. However, since the MBBS issue arose before the AAO, the authors believe that further specificity may be warranted. For example, this may include specifying in Section H.4B that the “Other” type of degree required is a “Doctor of Medicine (MD) degree,” indicating in H.9 that a foreign equivalent is acceptable and clarifying in Section J.11-A that the beneficiary holds a “foreign degree equivalent to a U.S. Doctor of Medicine (MD) degree.” In addition,

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203 See, e.g., Wikipedia entry for Bachelor of Medicine and Bachelor of Surgery degrees, which opines, “[t]he MB BS, MB ChB, BM BCh, MB BCh, BMed, MB BChir, MD, MDCM, BM BS, Dr.MuD, Dr.med, (etc) are all considered equivalent degrees.” http://en.wikipedia.org/wiki/Bachelor_of_Medicine_and_Surgery.

204 In re [name not provided], AAU EAC 98 008 50541, 1998 WL 34022271 (INS); In re [name not provided], AAU EAC 98 084 51540, 1999 WL 33589112 (INS); In re [name not provided], AAU SRC 06 264 52230. 2007 (USCIS).

205 Matter of [name not provided], SRC 08 186 52162 (USCIS Oct. 9, 2008).

206 See Texas Service Center (TSC) Practice Pointer, published on AILA InfoNet at Doc. No. 08101569 (posted Oct. 15, 2008) (reporting denials of I-140s without Requests for Evidence (RFE) or Notices of Intent to Deny (NOID)).

207 Supra notes 13 and 14.

208 Usually a labor certification case is pursued only after a foreign physician has obtained a full, unrestricted state license to practice medicine. Thus, it would seem that the distinction between MD degrees and foreign medical degrees that USCIS seeks to draw is a false distinction, if neither employers nor state medical licensing boards seek to draw this distinction.
the authors always obtain from a reputable and independent evaluator a credentials evaluation that confirms that such MBBS (or other foreign) degree is considered the equivalent of an advanced degree, namely, an MD degree.

In addition, practitioners should closely examine the medical school credentials underlying a foreign physician’s ECFMG certificate to determine the exact nature and duration of the medical education. Certainly, if the foreign physician had more than six years of post-secondary education, it is easier to argue that the medical degree is an advanced degree as opposed to a four-year course of study. In addition, in some countries, the alien’s medical education actually starts in secondary school. If it turns out that the MBBS alien’s secondary school transcripts reflect that the coursework during the last two years of secondary school was wholly or predominantly in the (medical) sciences, a credentials evaluator may reasonably conclude that the medical education culminating in the MBBS degree was seven and a half years (six years of coursework plus one and a half years of clinical experience) and, as such, was an “advanced degree.”

Identity of the Employer—
the Stark Laws and Ability to Pay

We now turn to an issue that, in our experience, presents particular difficulties in labor certification practice for foreign physicians—balancing the need at the I-140 stage to show “ability to pay” 209 with the realities of physician compensation in today’s health-care environment. This concerns the identity of the sponsoring employer, since it is the sponsoring employer’s ability to pay that USCIS scrutinizes at the I-140 stage.

In most labor certification cases in other industries, the identity of the employer is quite clear. But in many instances pertaining to physicians, this identification issue becomes quite complex in two specific ways: (1) identifying the actual employer of the physician; and (2) identifying whether or not an employer-employee relationship exists as required for labor certification application purposes.

Identity of Employer—Hospitals & the Stark Laws

The PERM regulation defines an employer as “a person, association, firm, or corporation that currently has a location within the United States to which U.S. workers may be referred for employment and that proposes to employ a full-time employee in a place within the United States, or the authorized representative of such a person, association, firm, or corporation.” 210 The definition goes on to limit the meaning of “authorized representative” to mean an employee of the employer whose position and legal status authorizes the employee to act for the employer in labor certification matters. Furthermore, the regulation specifically prohibits the approval of a labor certification application filed on behalf of an independent contractor.

Particularly in rural and small town locales, the local hospital is actively involved in the physician’s recruitment to and retention in the community, running from the recruitment/advertising effort and extending to direct financial and other services covering the start-up phase of the physician’s practice. It is common for the local hospital—often the “deep pocket” entity in the community—to provide the Physician with an income guarantee and to underwrite the acquisition of office space, staff, and equipment. Furthermore, in the discharge of his/her duties, the Physician quite possibly appears to be an employee of the hospital in that services are rendered on the hospital’s premises and there are other indicia of professional identification running from the business card to the doctor’s ID badge.

So, does this mean that the Physician is the hospital’s employee? Oftentimes, the answer is “no.” In fact, many states have outright prohibitions against a physician’s direct employment within a hospital. Rather, it is very common practice for a hospital to provide recruitment and practice management services, as well as start-up financial underwriting, on behalf a private medical employer in order to attract the Physician into the community.

The motivation of the hospital is not altruistic. Rather, in return for the hospital’s largesse, the Physician serves as a major utilizer and purchaser of hospital services as well as a referral source of patients to the hospital.

209 8 CFR §204.5(g)(2).

210 20 CFR §656.3.
In all likelihood, the Physician is employed by a private practice group, but that private practice group maintains a close, symbiotic relationship with the hospital.

At first glance, this would seem to be a highly questionable and impermissible arrangement in which the hospital provides financial support and seed money to lock in a Physician to referring patients to the hospital for services, treatment, and commitment. In general, the federal laws known as the Stark Laws create a strict prohibition against a Physician referring a patient to a medical facility in which the Physician has a financial interest, be it ownership or an investment interest, or a medical facility with which the Physician has a structured compensation arrangement under a belief that such arrangements lead to an over-utilization of medical services, a distortion of medical judgment, and a limitation on competition.

But there are certain limited exceptions to this general prohibition—exceptions that create a safe harbor from anti-kickback liability. Most relevant to our discussion is the exception permitting a hospital located in a designated medically underserved area to receive referrals of a recruited Physician if at least 75 percent of the recruited Physician’s revenue comes from patients who reside in qualifying medically underserved areas or are members of medically underserved populations, such as the homeless or migrant workers, and provided that the financial interest is limited to three years.

We contend that while many of the normal indicia used to identify an employer-employee relationship would seem to be present between referring physicians and hospitals, in reality, the physician is not an employee of the hospital. Rather, the employer of record for labor certification application purposes is the private clinical employer that maintains a close strategic relationship with the hospital. As such, it is this private entity that fulfills the definition of employer for the purposes of filing a labor certification application. The next question therefore becomes whether the private practice group for which the typical physician works can be an “employer” for labor certification purposes without running afoul of the definition of “employer” permitted under DOL labor certification regulations.

**Self-Incorporation and Independent Contractor Arrangements**

Physicians tend to work either as self-incorporated independent contractors who maintain a tight affiliation with an established medical practice or enter into medical practices with a clear path to partnership (ownership in the medical practice group). While common to the field of physician employment, neither of these arrangements is suitable for a labor certification-based case. For labor certification purposes, “employment” is defined as “permanent, full-time work by an employee for an employer other than oneself.” If the alien physician is one of several or more U.S. citizen or Permanent Resident physicians who own the practice group, arguably the physician is not truly self-employed; this argument is bolstered by the fact that the practice group usually has separate existence as a corporate entity with an Employer Identification Number (EIN) and might be taxed as an entity even if the owner/partners are taxed individually on their income from the practice as well. The substantial ownership interest the alien physician would have as a partner in a small practice group would

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211 42 USC §1395nn; 42 CFR §411.350 et. seq.


214 42 USC §1395nn(d); 42 CFR §§411.356(c), 411.357(t),

215 20 CFR §656.3.

216 Id.

217 *Id.* (“An employer must possess a valid Federal Employer Identification Number (FEIN).”)
undoubtedly trigger an audit by DOL to discern if the alien physician had undue control and influence over the job opportunity that may have tainted the recruitment process.\textsuperscript{218}

Therefore, from the inception of a labor certification case for a physician, the immigration practitioner must communicate to all parties that the best chance of success comes if the foreign physician is an employee of the medical practice, meaning that a salary needs to be paid that meets the prevailing wage figure as memorialized through the issuance of W-2 Forms. This disallows the quite common practice of having the physician’s compensation be set based on production (i.e., on number of patients seen). There is a strong tendency for a physician to work as an independent contractor so as to be paid “non-employee compensation” documented on a 1099 Form (instead of a W-2), and there are certainly a number of financial advantages to this arrangement from a financial and tax-planning standpoint. However, the private medical practice, as well as the foreign physician, need to be strongly educated on the necessity of maintaining an employer-employee relationship, certainly through the entire labor certification application process at least up to the point at which a physician can claim the benefit of adjustment portability under INA §204(j) after filing an I-485.\textsuperscript{219}

As one final Stark-related issue, we note that a physician working in a designated medically underserved area under the exemption from the Stark general ban on self-referrals unquestionably is authorized to receive payments from the local hospital. Such payments can either be remitted through the physician’s employer or directly to the physician.\textsuperscript{220} If payments are remitted directly to the physician, the following complications can and do arise: (1) whether the receipt of payments from a third party could be construed as unauthorized employment or whether it should be considered as an integral part of the physician’s employment agreement with the employing medical practice; (2) whether the actual employer of record can establish its ability to pay the physician’s wages at the time that the labor certification is filed, given that it has not availed itself of the financial payment made by the local “deep-pocketed” hospital; and (3) whether payment from the separate source of the hospital creates a problem in establishing the position’s prevailing wage since payments are being received from two separate entities—the actual employer of record and the local hospital underwriting the physician’s medical practice during the start-up phase.

Accordingly, it is our strong suggestion that in instances in which a Physician qualifies for the exemption to the Stark kick-back provisions—generally, situations in which a physician will be practicing in a designated medically underserved area—that the hospital remit its financial underwriting to the employer of record so as to eliminate any confusion as to the identity of the physician’s employer and fulfillment of prevailing wage standards.

**Alternative to Labor Certification—National Interest Waiver**

When considering a physician’s case for permanent residence, the practitioner should engage in an extended consideration as to whether the case should be structured under the labor certification application provisions or, if the physician is working in a designated medically underserved area, as a National Interest Waiver (NIW). Just as physicians face certain nuances in the labor certification application process, there are some special considerations that may counsel that the physician’s case be structured under the special NIW provisions covering physician services in designated medically underserved areas.

\textsuperscript{218} 20 CFR §656.17(l).

\textsuperscript{219} USCIS has affirmed that in §204(j) portability cases, porting to self-employment is permitted. See USCIS Memorandum, supra note 151, at 4, Q&A #8.

\textsuperscript{220} Supra note 76.
In the aftermath of Matter of New York State Department of Transportation (NYSDOT),221 most clinical physicians lost their eligibility for NIW benefits, largely owing to their inability to meet the third prong of the NYSDOT test of showing factors that would offset the need to test the labor market. Thereafter, the INA was amended to create a presumption of NIW entitlement to physicians who commit to practice in a designated medically underserved area, provided that the physician agrees to work in the community for a five-year period of time.222 However, the implementing regulations somewhat limited the attractiveness of this NIW option by injecting the following provisions: (1) a limitation of NIW eligibility solely to primary care physicians; (2) a requirement that the five-year period of service be accomplished within a six-year period of time; and (3) artificial distinctions on periods of employment that would be credited toward meeting the five-year required period of service.223

As a result of the federal court decision in Schneider v. Chertoff,224 the USCIS Adjudicator’s Field Manual (AFM)225 has now been revised in a manner that broadens substantially the eligibility of physicians to qualify for permanent residence under the NIW provisions.226 While the statutory requirement remains that a physician needs to commit to a five-year period of employment in a designated medically underserved area, the interpretation of the law has recently been amended in the following manner: (1) all physicians—whether practicing primary care or specialty care medicine—qualify for NIW approval; (2) there is no stipulated period of time within which the five-year period needs to be completed; (3) all periods of authorized employment count against the five-year service obligation; and (4) a reiteration that a physician can be self-employed or hold a position as partner and still obtain benefits under the national interest waiver provisions.227

These changes, as well as the restrictions on customary physician compensation schemes discussed above that do not square with the confines of labor certification requirements, make it important to assess thoroughly the relative strategic merits between the NIW and a labor certification application. Among the factors that would counsel for using the NIW approach would be:

- The physician is very satisfied with the community and his/her job so as to accept the prospect of working in the employment position for, at minimum, a full five-year period of time.


223 8 CFR §204.12.

224 Schneider v. Chertoff, 450 F.3d 944 (9th Cir. 2006).


226 USCIS Memorandum, “Interim guidance for adjudication national interest waiver (NIW) petitions and related adjustment applications for physicians serving in medically underserved areas in light of Schneider v. Chertoff, 450 F.3d 944 (9th Cir. 2006) (Schneider decision)” (Jan. 23, 2007), published on AILA InfoNet at Doc. No. 07021262 (posted Feb. 12, 2007).

227 Id.
The employer refuses or is otherwise unable to pay the fees and costs associated with the alien’s immigration case (in particular, the labor certification application); there is no similar prohibition on alien payment of attorney’s fees for a self-petition NIW.

The physician is working as an Independent Contractor or a Partner in the medical practice.

For physicians previously in an ECFMG-sponsored J-1 program approved for a waiver of the two-year home residence obligation under INA §214(l), the ability to provide the J-2 dependents with employment authorization during the mandatory three-year H-1B service obligation, which normally prohibits filing of an adjustment of status application during the three-year period.228

If the physician desires to undertake further periods of GME, this is now feasible given the elimination of the stipulated six-year period in which to fulfill the five-year employment obligation.

If the physician is working with a newly established medical employer, a closely held corporation, or a medical practice experiencing financial difficulties that may have difficulties in showing its ability to pay the wages at the time that the case is commenced, an NIW might be favored.

If the physician is working based on production rather than per a set, guaranteed salary so as to raise issues on ascertaining (never mind meeting) the prevailing wage.

Conversely, the labor certification application could well be a more suitable approach for the individual’s needs if:

- The physician desires to limit the required period of employment as much as possible.
- The physician is not working in a designated medically underserved area which is a prerequisite to national interest waiver eligibility.
- The employer agrees to actively and energetically support the physician’s attainment of permanent residence through the labor certification application process, including payment of attorney’s fees and recruitment costs for the labor certification stage of the case.

As a final comment on the possibility of pursuing an NIW, we note that nothing prevents a physician from pursuing both an NIW and a labor certification, should one become more attractive than the other over the course of both cases.

CONCLUSION

The purpose of this article has been to present to the practitioner some of the more nettlesome issues that affect labor certification practice for Physicians. We again want to stress that the basic themes of the “normal” labor certification application process apply fully in the Physician context. But there are, unquestionably, nuances and special considerations of which the practitioner needs to be aware when formulating a labor certification case for an IMG—factors generally sourced in the complexities arising from the lengthy periods of training, the multiple organizations that monitor, license, and accredit Physicians, and the basic nature of medical practice in the United States.

In many ways, the immigration attitude toward Physicians is changing. Previously, the essential attitude was that the United States had too many Physicians with the result that immigration law and policy contained various seemingly restrictionist measures, such as: constrictive J-1 waiver options; narrow, unyielding NIW standards; tight credentialing standards for H-1B purposes. At present, there is a growing realization that there are substantial and pervasive shortages in the Physician workforce and that a more assertive, activist immigration policy can serve national objectives of increasing the supply and accessibility of Physicians to the U.S. populace. Slowly, ever so slowly, immigration provisions for Physicians are adapting to this new reality—mainly in the J-1

waiver arena but also to some extent in providing new options for permanent residence based on the practice of medicine.

If we can share one overarching final thought it would be the following: The practitioner’s basic challenge in representing Physicians in labor certification (or other) cases is not simply to understand immigration law, but equally importantly to understand the environment in which Physicians work—the culture, professional pressures, lexicon, aspirations, economics, credentialing requirements, and overall complexities of practicing medicine in the United States. In our opinion, both the challenge and the ultimate satisfaction of representing Physicians—and an indispensable requirement for quality professional representation—requires an understanding of certain factors unique to the medical profession. This article is one attempt to orient the immigration practitioner to considerations peculiar to Physicians that arise when pursuing permanent residence through the labor certification application process.

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When an “Affiliate” is Not an “Affiliate”:
The Strange Intersection of Immigration and Corporate Law
By Wendy Castor Hess

Immigration law is a strange and complex beast. As Judge Kaufman stated in 1976:

> We have occasion to note the striking resemblance between some of the laws we are called upon to interpret and King Minos’s labyrinth in ancient Crete. The Tax Laws and the Immigration and Nationality Acts are examples we have cited of Congress’s ingenuity in passing statutes certain to accelerate the aging process of judges… Congress, pursuant to its virtually unfettered power…, and apparently confident of the aphorism that human skill, properly applied, can resolve any enigma that human inventiveness can create, has enacted a baffling skein of provisions for the [legacy] I.N.S. and courts to disentangle.229

The immigration laws are replete with ambiguities in both the statute and implementing regulations. Thus, in March of 2011, when the U.S. Citizenship and Immigration Services (USCIS) (the agency responsible for regulating immigration benefits), abruptly (and without notice), departed from its long-standing interpretation of a critical provision of the law, the beast began to roar. It was at this time, a critical time in the world of medicine, that USCIS unilaterally decided to re-interpret the term “affiliate”, as it pertained to H-1B Petitions filed by non-profit hospitals affiliated with institutions of higher education, which sought to employ foreign medical graduates (FMGs) in their residency and fellowship programs.

In order to understand the significance of such changed interpretation, it is critical to understand the basics: FMGs who come to the U.S. to pursue graduate medical training do so pursuant to two types of non-immigrant visas—either J-1 230 or H-1B visas231. Both are temporary visas that grant the FMG a fixed period of time in which to remain in the U.S., but the similarity ends here. J-1 physicians are sponsored by the Educational Council for Foreign Medical Graduates (ECFMG), at little or no cost and with no limit to the numbers of physicians who may enter the U.S. pursuant to such visa classification each year. Physicians holding J-1 status are subject to the dreaded “two-year foreign residence requirement,” requiring them to


230 INA §101(a)(15)(J).

231 INA §101(a)(15)(H).
return to their home countries at the conclusion of their training. H-1B physicians, unlike their J-1 counterparts, are sponsored by the employing medical institution, which are required to pay costly immigration filing and legal fees. Still, despite this added financial cost, H-1B physicians enjoy a great benefit: they are eligible to remain in the U.S. after completion of their medical training, provided they maintain their H-1B status or obtain lawful permanent resident status, without returning to their home country.

In immigration law, nothing is as good as it first looks and this holds true for H-1B physicians who are faced with a different problem: the annual numerical H-1B cap. Specifically, H-1B visas are limited to 65,000 per year, with an additional 20,000 allocated to those who hold U.S. masters degrees. These “cap subject” visas first become available on October 1, the beginning of the USCIS fiscal year, which does not meet the needs of the academic cycle of medical trainees, who must begin their programs in June or July. Problematically, in prior years, due to high demand, H-1B visas were gobbled up as quickly as they were released, ensuring that the annual cap would be reached by the time medical residents actually needed them.

For this reason and showing rare foresight, in 2000, Congress exempted from this H-1B cap beneficiaries who are employed at an “institution of higher education” or a “related or affiliated nonprofit entity” or a nonprofit or governmental research organization. The legislative history notes: “U.S. universities are on a different hiring cycle than other employers. The H-1B cap has hit them hard because they often do not hire until the numbers have been used up; and because of the academic calendar, they cannot wait until October 1, the new fiscal year, to start a class.”

Thus, for more than a decade, non-profit hospitals that had affiliation agreements with institutions of higher education relied on such “cap exemption” to secure H-1B visas for their FMGs. However, in early March 2011, USCIS abruptly changed its long relied upon interpretation of the term “affiliated nonprofit entity” and began denying Petitions filed by such hospitals on the basis that there had to be “shared ownership or control” for two entities to be affiliated, quite contrary to the accepted standard practices in the health care industry.

The timing could not have been worse: reports of such denials surfaced just days before the biggest event in graduate medical education, the annual March “match” of the National Resident Matching Program, the program by which medical residents are matched with the hospitals in which they will be training.

The medical community was in an uproar, for prior to such time, it had been tacitly understood that hospital affiliation agreements are not necessarily the same as affiliation agreements in the corporate world and hence USCIS’ interpretation of “affiliation”, as applied to hospitals, reflected the reality of the medical community. With contractual offers extended to thousands of FMGs and U.S. hospitals counting on them to arrive on

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232 Pursuant to INA §212(e), a J-1 who comes to the U.S. to pursue graduate medical education must reside or be physically present in his country of nationality or last residence for an aggregate period of two years before he is eligible to apply for an immigrant visa, for permanent residence or for H or L nonimmigrant classification. Waivers are available.

233 INA §214(g)(1)(A).

234 Pursuant to 8 CFR §214.2(h)(9)(B), employers may file H-1B Petitions up to six months before the date of actual need for the beneficiary’s services or training (i.e. as early as April 1 for “cap subject” H-1B Petitions).


236 INA §214(g)(5)(B).

time, the medical community (and their immigration counsel) sprang into action. The result was a truce of sorts: USCIS issued interim guidance, giving deference to prior H-1B cap exemption determinations, as USCIS conducted an internal review of its overall policy on cap exemption for related or affiliated nonprofit entities. While such guidance has helped those hospitals that have had a “cap exempt” H-1B Petition previously approved, it has not helped similarly-situated hospitals wishing to file an H-1B Petition for the first time. Quite troubling, this interim guidance is merely a band aid approach to an oozing wound that exemplifies the inability of the U.S. immigration laws to reflect the needs of the very same business community they were drafted to assist. 238 Sadly, 35 years after his decision in Lok v. Immigration and Naturalization Service, Judge Kaufmann’s words still ring true: the immigration laws continue to be similar to King Minos’ labyrinth, with a dose of reality still missing.

238 In fact, as of the writing of this article and despite USCIS’ March 18, 2011 Press Release, USCIS, H-1B Cap Exemptions Based on Relation or Affiliation, published on AILA Infonet at Doc. No.11031760 (posted Mar. 24, 2011), promising further guidance, USCIS still has not issued a definitive statement that offers any more certainty or clarity regarding who is exempt under the “affiliated or related” standard.