Washington University in St. Louis

Office for International Students and Scholars

J-1 Patient Contact Form

Updated 07/2024

Option I **OR** Option II below is to be completed by the J-1 Exchange Visitor's host department chair and supervisor. The information on this form must accurately reflect the type of patient contact that the physician will have. This form should be emailed to the prospective J-1 physician for signature. Please attach this completed form with J-1 Request documents.

Option I: J-1 program will not involve patient contact

If the J-1 physician is coming to WashU to pursue a program that does not involve patient contact, the applicant's WashU sponsor must certify the following:

This certifies that the program in which   is to be engaged is solely for the purpose of observation, consultation, teaching, or research, and that no element of patient care services is involved.

Department Chair Name	*Department Chair Signature*	*Date*
Faculty Sponsor Name	*Faculty Sponsor Signature*	*Date*

Option II: Incidental patient contact will occur

If incidental patient contact is involved in the J-1 Exchange Visitor's duties, the WashU sponsor must certify the following five points:

1. The program in which   will participate is predominantly involved in observation, consultation, teaching or research.
2. Any incidental patient contact involving the J-1 physician will be under the direct supervision of a physician who is a U.S. citizen or resident alien and who is licensed to practice medicine in the state of Missouri.
3. The J-1 physician will not be given final responsibility for the diagnosis and treatment of patients.
4. Any activities of the J-1 physician will conform fully with state licensing requirements and regulations for medical and health care professionals in the state of Missouri.
5. Any experience gained in this program will not be creditable toward any clinical requirements for medical specialty board certification.

Department Chair Name	*Department Chair Signature*	*Date*
Faculty Sponsor Name	*Faculty Sponsor Signature*	*Date*

To be completed by prospective J-1 Exchange Visitor

I understand and agree with the above statement(s) regarding the level of patient contact I will have during my proposed activity at WashU.

Full Name:

Signature: Date:

If the J-1 physician's program involves significant patient contact or otherwise does not conform with the selected option above, the physician cannot be sponsored through the WashU J-1 Exchange Visitor Program.