Intealth®
Advancing the Global Health Workforce

Exchange Visitor Sponsorship Program (EVSP)

Attestation of Supplemental Clinical Activity within the Training Institution

For J-1 Physicians Sponsored by Intealth dba ECFMG (Program Number P-3-04510)

This form must be completed and signed by the J-1 physician's program director and submitted to Intealth by the institution's Training Program Liaison (TPL) prior to the start of any program-authorized supplemental clinical duties. A copy of the form must also be retained by the training program in the physician's file. This form is valid for one clinical training year only. A new form is required for each additional year and associated subsequent activity.

J-1 PHYSICIAN INFORMATION

Physician Name: ______________________ MyIntealth ID or USMLE ID: ____________

Specialty / Subspecialty: ______________________

Type of Program: ☐ ACGME-accredited ☐ Non-standard (NST)

Training Year Start Date:	
Training Year End Date:	

ACTIVITY DETAILS

Description of supplemental clinical duties within the training program (include clinical setting, responsibilities, and purpose):

Location of supplemental clinical activity:

☐ Primary clinical site of training program

☐ Participating clinical site of training program

Note: *Supplemental clinical activity must occur at the same institution/primary clinical site or participating clinical site where the physician is engaged in their training program.*

Proposed duration of supplemental clinical activity:

Activity Start Date:	
Activity End Date:	

Note: *Supplemental clinical activity cannot extend beyond the J-1 physician's current training year end date.* ***This form is valid for one training year only.***

Estimated additional annual income (Intealth must report this on Form DS-2019): $

*Proceed to the next page. This form **will not** be accepted without page 2.* ⟶

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PROGRAM DIRECTOR ATTESTATION

Responsible Officer Approval Protocol

Intealth's Responsible Officer for the J-1 Exchange Visitor Program accepts the program director's professional judgment in determining whether proposed supplemental clinical activity complies with all applicable requirements, including institutional policies, ACGME duty hour limitations, and the goals of graduate medical education.

By signing this form, the program director affirms that:

- All criteria for the supplemental clinical activity have been reviewed and satisfied;
- The proposed activity does not interfere with the physician's core training responsibilities, duty hour limitations, or overall educational objectives.

The Department of State requires that both the program director and the Responsible Officer approve the activity before it can be authorized. Submission of this signed form serves as the required prior written approval from both parties.

By signing below, I confirm and certify that:

1. I have reviewed the proposed supplemental clinical activity and approve the physician's participation.
2. The activity:
    - Complies with institutional policies and ACGME duty hour limitations
    - Does **not** interfere with the physician's core training responsibilities or educational objectives
    - Will **not** extend the duration of the training program
3. The physician remains in good standing within their program.
4. I agree to maintain a copy of this completed form in the physician's program file.

Program Director Name: ____

Title: ____

Institution: ____

Email: ____

Program Director Signature: ______________________________ Date: ______________

SUBMISSION INSTRUCTIONS

Training Program Liaisons (TPLs) must upload the completed form to the applicant's record. Forms submitted directly by the J-1 physician will not be accepted.

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