University Medical Resident Services, P.C.
H-1B QUESTIONNAIRE FOR MEDICAL RESIDENTS

SECTION 1: ABOUT THE MEDICAL RESIDENT:
(To be completed by the Medical Resident)

Name:_____
Last/Family *First* *Middle*

Date of birth: _____/_____/_____ U.S. Social Security #: _____-_____-_____
MM DD YY

Country of birth: _____ City of birth: _____

Province/State of birth: _____ Country of citizenship: _____

Residence address in the U.S. _____

_____
(Please note that USCIS and Immigration Services must be notified within 10 days of a change of residence address. Use Form AR-11, available on UB Immigration Services web site to notify of change of address.)

Telephone numbers: _____ (home) _____ (work)

E-mail address*:* _____

Most recent residence address in home country:

_____
Street Address

_____
City *State/Province* *Postal Code* *Country*

IMMIGRATION HISTORY:
Please answer ALL questions.

If the individual is in the U.S., provide current immigration status: _____

Expiration date of current status: _____/_____/_____
MM DD YY

Within the past 7 years, has the individual
- been granted H-1B status? _____ Yes _____ No
- been denied H-1B status? _____ Yes _____ No

If yes, please provide the full name of the employer, the dates of employment and the USCIS receipt number.
_____

_____

Has the individual ever been granted J-1 or J-2 status? _____ Yes _____ No
If yes, was the individual subject to the two-year home residency requirement? ___ ____Yes _ ____ No

Has the individual ever been granted another immigration status? _____Yes _____ No

If yes, please provide details _____

Note:
The information requested below is a required field on the H-1B petition.
It must be completed whether the employee is in the U.S. or not and whether or not the individual intends to apply for an H-1B visa.

Choice of U. S. Consulate or Embassy abroad:

City: _____ Country: _____ Border Post *(Canadians Only):*_____

Reminder:
The H-1B petition cannot be filed without the above information.

DEPENDENTS IN THE UNITED STATES:

If the individual is in the United States with spouse and/or child/ren, please indicate:

Name	Date of Birth	Country of Birth	Immigration Status	Relationship

I certify under penalty of perjury that the information I have provided above and in support of my request of H-1B status and of H-4 status for my dependents, if any, is correct and complete to the best of my recollection and ability. I acknowledge that I have a duty to fully disclose my immigration matters to University Medical Resident Services, P.C. and to UB Immigration Services and that my failure to comply with that requirement may result in denial or revocation of my immigration benefits by USCIS. I also acknowledge that I am solely responsible for maintaining my status and that of my dependents.

_____
Signature

_____
Print Name

_____
Date

SECTION 2: ABOUT THE RESIDENCY PROGRAM:

(To be completed by the Program Administrator)

Time period for which seeking H-1B status (maximum of **3 years** per request, *e.g. 6/1/02-5/31/05.*):

From: ____/____/____ To: ____/____/____
MM DD YY *MM DD YY*

Residency Program: _____ Level of Position: PGY-_____(1-7)

Program Director's Name and Title: _____

Program Director's E-mail Address: _____

Primary Training Hospital: _____

Program Phone #: _____

Program Administrator's Name: _____

Program Administrator's E-mail Address: _____

Salary: $_____ per year. Degree Required: _____
(Please specify M.D., M.B.B.S., D.O., etc.)

Experience Required: _____
(e.g. completion of PGY-1, etc.)

Other Special Requirements *(e.g. licenses, certifications, familiarity with techniques, etc.)*:

_____

PROGRAM CERTIFICATION

I (Program Director submitting the H-1B request) hereby certify that I have reviewed this form and understand that it binds University Medical Resident Services, P.C., to all terms of the H-1B status for the period requested, including payment of return air transportation home if the foreign national employee is dismissed before the expiration of the time requested.

Program Director Name: _____

Program Address: _____

Phone Number: _____

Program Director Signature and Date: _____

University Medical Resident Services, P.C. representative: _____
Amanda Schiedel, Human Resources Manager

Date: _____