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: ______________________________________

Colleen M. Allen, Assistant Secretary

Date: ________________________________