



Department of Human Resources
University of Massachusetts Medical School
333 South Street (Shrewsbury Campus)
Shrewsbury, MA 01545 USA
508.856.5260 (office) select option 3
508.856.5922 (fax)

MD Statement

To be completed by sponsoring UMMS department and submitted to the Immigration Services Office as part of the Immigration Packet (request for visa sponsorship) for any prospective exchange visitor, employee or contingent worker who holds a Medical Degree (MD) or the equivalent.

Information about UMMS appointee:

Name (as it appears in passport): _____
(Family Name) _____ (Given Name(s)) _____

Sponsoring UMMS Department: _____

UMMS Position Title: _____

MD Certification

If the individual requesting immigration sponsorship (J-1, H-1B, etc.) holds an M.D. degree or equivalent, please read the following statements and indicate which one applies:

The program in which the individual will be engaged is solely for the purpose of observation, consultation, teaching, or research and no element of patient care is involved.

The program in which the individual will be engaged involves some element of patient contact. As the sponsoring department, we understand that this program must meet the following criteria:

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

Name of PI/Department Chief/or Authorized Department Administrator

Signature of PI/Department Chief/or Authorized Department Administrator

Date