



New H-1B Department Checklist

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| Employee Name: | |
| A-Number: | |
| Index Number: | |
| Job Title: | |
| Salary: | |
| Work Location: | |
| DP Code: | |

| | |
|------------------|--|
| Department Head: | |
| Phone Number: | |
| Email Address: | |

Sponsorship Time: 1 year 2 years 3 years

Date Range: _____ (MM/DD/YYYY to MM/DD/YYYY)

If the applicant's education requires an US equivalency evaluation, is the department willing to pay for it? Est cost: \$150 Yes No

Will the employee be engaged in any research or other sponsored activities involving confidential, proprietary, or [export controlled](#) data, equipment, or software?

Yes No

Please upload the following information into the box link provided in the email:

- A detailed breakdown of the job description or role statement, include percentages
- A short and generalized job description that is only one to two paragraphs
- Signed offer letter on the departments letter head

By completing this form, I agree to, and will abide by, the terms of the labor condition application ([LCA](#)) for the duration of the beneficiary's authorized period of stay for H-1B employment. I certify that I will maintain a valid employer-employee relationship with the beneficiary at all times. If the beneficiary is assigned to a position in a new location, I will contact HR to obtain and post an LCA for that site prior to reassignment.

I further understand that I cannot charge the beneficiary the ACWIA fee, and that any other required reimbursement will be considered an offset against wages and benefits paid relative to the LCA.

If you knowingly and willfully falsify or conceal a material fact or submit a false document with this form, the petition may be denied and USCIS may deny any other immigration benefit for this beneficiary.

As an authorized official of the employer, I certify that the employer will be liable for the reasonable costs of return transportation of the beneficiary abroad if the beneficiary is dismissed from employment by the employer before the end of the period of authorized stay.

Signature: _____ Date: _____
(Department Head)