OMB Approval: 1205-0310
Expiration Date: 01/31/2012

Labor Condition Application for Nonimmigrant Workers
ETA Form 9035 & 9035E
U.S. Department of Labor

Electronic Filing of Labor Condition Applications For The H-1B Nonimmigrant Visa Program

This Department of Labor, Employment and Training Administration (ETA), electronic filing system enables an employer to file a Labor Condition Application (LCA) and obtain certification of the LCA. This Form must be submitted by the employer or by someone authorized to act on behalf of the employer.

A) I understand and agree that, upon my receipt of ETA's certification of the LCA by electronic response to my submission, I must take the following actions at the specified times and circumstances:

- print and sign a hardcopy of the electronically filed and certified LCA;
- maintain a signed hardcopy of this LCA in my public access files;
- submit a signed hardcopy of the LCA to the United States Citizenship and Immigration Services (USCIS) in support of the I-129, on the date of submission of the I-129;
- provide a signed hardcopy of this LCA to each H-1B nonimmigrant who is employed pursuant to the LCA.

☑ Yes ❑ No

B) I understand and agree that, by filing the LCA electronically, I attest that all of the statements in the LCA are true and accurate and that I am undertaking all the obligations that are set out in the LCA (Form ETA 9035E) and the accompanying instructions (Form ETA 9035CP).

☑ Yes ❑ No

C) I hereby choose one of the following options, with regard to the accompanying instructions:

❑ I choose to have the Form ETA 9035CP electronically attached to the certified LCA, and to be bound by the LCA obligations as explained in this form

☑ I choose not to have the Form ETA 9035CP electronically attached to the certified LCA, but I have read the instructions and I understand that I am bound by the LCA obligations as explained in this form

Case Number: T-200-12062-824866 Case Status: INITIATED Period of Employment: 06/22/2012 to 06/30/2012

OMB Approval: 1205-0310
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Please read and review the filing instructions carefully before completing the ETA Form 9035 or 9035E. A copy of the instructions can be found at http://www.foreignlaborcert.doleta.gov/. In accordance with Federal Regulations at 20 CFR 655.730(b), incomplete or obviously inaccurate Labor Condition Applications (LCAs) will not be certified by the Department of Labor. If the employer has received permission from the Administrator of the Office of Foreign Labor Certification to submit this form non-electronically, ALL required fields/items containing an asterisk (*) must be completed as well as any fields/items where a response is conditional as indicated by the section (§) symbol.

A. Employment-Based Nonimmigrant Visa Information

1. Indicate the type of visa classification supported by this application *(Write classification symbol)*: *	H-1B

B. Temporary Need Information

1. Job Title * MEDICAL RESIDENT PGY-3		
2. SOC (ONET/OES) code * 29-1069	3. SOC (ONET/OES) occupation title * PHYSICIANS AND SURGEONS, ALL OTHER	
4. Is this a full-time position? * ☑ Yes ☐ No	**Period of Intended Employment**	
	5. Begin Date * *(mm/dd/yyyy)* 06/22/2012	6. End Date * *(mm/dd/yyyy)* 06/30/2012

7. Worker positions needed/basis for the visa classification supported by this application

1 **Total Worker Positions Being Requested for Certification ***

Basis for the visa classification supported by this application
(*indicate the total workers in each applicable category based on the total workers identified above*)

1	a. New employment *	0	d. New concurrent employment *
0	b. Continuation of previously approved employment * without change with the same employer	0	e. Change in employer *
0	c. Change in previously approved employment *	0	f. Amended petition *

C. Employer Information

1. Legal business name * STATE UNIVERSITY OF NEW YORK AT BUFFALO		
2. Trade name/Doing Business As (DBA), if applicable UNIVERSITY AT BUFFALO		
3. Address 1 * 117 CARY HALL		
4. Address 2 OFFICE OF GRADUATE MEDICAL EDUCATION		
5. City * BUFFALO	6. State * NY	7. Postal code * 14214
8. Country * UNITED STATES OF AMERICA	9. Province N/A	
10. Telephone number * 7168296128	11. Extension N/A	
12. Federal Employer Identification Number (FEIN from IRS) * 146013200	13. NAICS code (must be at least 4-digits) * 611310	

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D. Employer Point of Contact Information

Important Note: The information contained in this Section must be that of an employee of the employer who is authorized to act on behalf of the employer in labor certification matters. The information in this Section must be different from the agent or attorney information listed in Section E, unless the attorney is an employee of the employer.

1. Contact's last (family) name *	2. First (given) name *	3. Middle name(s) *
CUMMISKEY	DONNA	M.

4. Contact's job title *	DIRECTOR, GRADUATE MEDICAL EDUCATION RESOURCE MGT.
5. Address 1 *	117 CARY HALL
6. Address 2	OFFICE OF GRADUATE MEDICAL EDUCATION

7. City *	8. State *	9. Postal code *
BUFFALO	NY	14214

10. Country *	11. Province
UNITED STATES OF AMERICA	N/A

12. Telephone number *	13. Extension	14. E-Mail address
7168296128	N/A	DMC23@BUFFALO.EDU

E. Attorney or Agent Information (If applicable)

1. Is the employer represented by an attorney or agent in the filing of this application? * If "Yes", complete the remainder of Section E below.	☑ Yes ☐ No

2. Attorney or Agent's last (family) name §	3. First (given) name §	4. Middle name(s) §
BUDDE	OSCAR	ARIEL

5. Address 1 §	STATE UNIVERSITY OF NEW YORK AT BUFFALO
6. Address 2	210 TALBERT HALL

7. City §	8. State §	9. Postal code §
BUFFALO	NY	14260

10. Country §	11. Province
UNITED STATES OF AMERICA	N/A

12. Telephone number §	13. Extension	14. E-Mail address
7166455550	N/A	IMMSVCGA@BUFFALO.EDU

15. Law firm/Business name §	16. Law firm/Business FEIN §
STATE UNIVERSITY OF NEW YORK AT BUFFALO	146013200

17. State Bar number (only if attorney) §	18. State of highest court where attorney is in good standing (only if attorney) §
70552	OHIO

19. Name of the highest court where attorney is in good standing (only if attorney) §
SUPREME COURT OF OHIO

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F. Rate of Pay

1. Wage Rate (Required)	2. Per: (Choose only one) *
From: $ 46135.00 * To: $ N/A	☐ Hour ☐ Week ☐ Bi-Weekly ☐ Month ☑ Year

G. Employment and Prevailing Wage Information

Important Note: It is important for the employer to define the place of intended employment with as much geographic specificity as possible The place of employment address listed below must be a physical location and cannot be a P.O. Box. The employer may use this section to identify up to three (3) physical locations and corresponding prevailing wages covering each location where work will be performed and the electronic system will accept up to 3 physical locations and prevailing wage information. If the employer has received approval from the Department of Labor to submit this form non-electronically and the work is expected to be performed in more than one location, an attachment must be submitted in order to complete this section.

a. Place of Employment 1 (Also see ADDENDUM 1 - Additional Worksites)

1. Address 1 * STATE UNIVERSITY OF NEW YORK AT BUFFALO	
2. Address 2 117 CARY HALL	
3. City * BUFFALO	4. County * ERIE
5. State/District/Territory * NEW YORK	6. Postal code * 14214

Prevailing Wage Information *(corresponding to the place of employment location listed above)*

7. Agency which issued prevailing wage § N/A	7a. Prevailing wage tracking number (if applicable) § N/A
8. Wage level * ☐ I ☐ II ☐ III ☐ IV ☑ N/A	
9. Prevailing wage * $ 46135.00	10. Per: (Choose only one) * ☐ Hour ☐ Week ☐ Bi-Weekly ☐ Month ☑ Year
11. Prevailing wage source (Choose only one) * ❑ OES ❑ CBA ❑ DBA ❑ SCA ☑ Other	
11a. Year source published * 2011	11b. If "OES", and SWA/NPC did not issue prevailing wage **OR** "Other" in question 11, specify source § AAMC SURVEY OF RESIDENT/FELLOW STIPENDS AND BENEFITS

H. Employer Labor Condition Statements

! ***Important Note:*** In order for your application to be processed, you MUST read Section H of the Labor Condition Application – General Instructions Form ETA 9035CP under the heading "Employer Labor Condition Statements" and agree to all four (4) labor condition statements summarized below:

(1) **Wages:** Pay nonimmigrants at least the local prevailing wage or the employer's actual wage, whichever is higher, and pay for non-productive time. Offer nonimmigrants benefits on the same basis as offered to U.S. workers.
(2) **Working Conditions:** Provide working conditions for nonimmigrants which will not adversely affect the working conditions of workers similarly employed.
(3) **Strike, Lockout, or Work Stoppage:** There is no strike, lockout, or work stoppage in the named occupation at the place of employment.
(4) **Notice:** Notice to union or to workers has been or will be provided in the named occupation at the place of employment. A copy of this form will be provided to each nonimmigrant worker employed pursuant to the application.

1. **I have read and agree to** Labor Condition Statements 1, 2, 3, and 4 above and as fully explained in Section H of the Labor Condition Application – General Instructions – Form ETA 9035CP. *	☑ Yes ❑ No

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I. Additional Employer Labor Condition Statements – H-1B Employers ONLY

! **Important Note**: In order for your H-1B application to be processed, you MUST read Section I – Subsection 1 of the Labor Condition Application – General Instructions Form ETA 9035CP under the heading "Additional Employer Labor Condition Statements" and answer the questions below.

a. Subsection 1 (Also see ADDENDUM 1 - Additional Worksites)

1. Is the employer H-1B dependent? §	❑ Yes ☑ No
2. Is the employer a willful violator? §	❑ Yes ☑ No
3. If "Yes" is marked in questions I.1 and/or I.2, you must answer "Yes" or "No" regarding whether the employer will use this application ONLY to support H-1B petitions or extensions of status for exempt H-1B nonimmigrants? §	❑ Yes ❑ No ☑ N/A

If you marked "Yes" to questions I.1 and/or I.2 and "No" to question I.3, you MUST read Section I – Subsection 2 of the Labor Condition Application – General Instructions Form ETA 9035CP under the heading "Additional Employer Labor Condition Statements" and indicate your agreement to all three (3) additional statements summarized below.

b. Subsection 2

A. **Displacement:** Non-displacement of the U.S. workers in the employer's workforce
B. **Secondary Displacement:** Non-displacement of U.S. workers in another employer's workforce; and
C. **Recruitment and Hiring:** Recruitment of U.S. workers and hiring of U.S. workers applicant(s) who are equally or better qualified than the H-1B nonimmigrant(s).

4. **I have read and agree** to Additional Employer Labor Condition Statements A, B, and C above and as fully explained in Section I – Subsections 1 and 2 of the Labor Condition Application – General Instructions Form ETA 9035CP. §	❑ Yes ❑ No

J. Public Disclosure Information

! **Important Note**: You must select from the options listed in this Section.

1. Public disclosure information will be kept at: *	☑ Employer's principal place of business ❑ Place of employment

K. Declaration of Employer

By signing this form, I, on behalf of the employer, attest that the information and labor condition statements provided are true and accurate; that I have read sections H and I of the Labor Condition Application – General Instructions Form ETA 9035CP, and that I agree to comply with the Labor Condition Statements as set forth in the Labor Condition Application – General Instructions Form ETA 9035CP and with the Department of Labor regulations (20 CFR part 655, Subparts H and I). I agree to make this application, supporting documentation, and other records available to officials of the Department of Labor upon request during any investigation under the Immigration and Nationality Act. Making fraudulent representations on this Form can lead to civil or criminal action under 18 U.S.C. 1001, 18 U.S.C. 1546, or other provisions of law.

1. Last (family) name of hiring or designated official *	2. First (given) name of hiring or designated official *	3. Middle initial *
CUMMISKEY	DONNA	M.
4. Hiring or designated official title *		
DIRECTOR, GRADUATE MEDICAL EDUCATION RESOURCE MGT.		
5. Signature *	6. Date signed *	

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L. LCA Preparer

Important Note: Complete this section if the preparer of this LCA is a person other than the one identified in either Section D (employer point of contact) or E (attorney or agent) of this application.

1. Last (family) name §	2. First (given) name §	3. Middle initial §
BUDDE	OSCAR	A.
4. Firm/Business name § STATE UNIVERSITY OF NEW YORK AT BUFFALO		
5. E-Mail address § IMMSVCGA@BUFFALO.EDU		

M. U.S. Government Agency Use (ONLY)

By virtue of the signature below, the Department of Labor hereby acknowledges the following:

This certification is valid from _____ to _____.

Department of Labor, Office of Foreign Labor Certification	Determination Date (date signed)
T-200-12062-824866	INITIATED
Case number	Case Status

The Department of Labor is not the guarantor of the accuracy, truthfulness, or adequacy of a certified LCA.

N. Signature Notification and Complaints

The signatures and dates signed on this form will not be filled out when electronically submitting to the Department of Labor for processing, but **MUST** be complete when submitting non-electronically. If the application is submitted electronically, any resulting certification **MUST** be signed *immediately upon receipt* from the Department of Labor before it can be submitted to USCIS for further processing.

Complaints alleging misrepresentation of material facts in the LCA and/or failure to comply with the terms of the LCA may be filed using the WH-4 Form with any office of the Wage and Hour Division, Employment Standards Administration, U.S. Department of Labor. A listing of the Wage and Hour Division offices can be obtained at http://www.dol.gov/esa. Complaints alleging failure to offer employment to an equally or better qualified U.S. worker, or an employer's misrepresentation regarding such offer(s) of employment, may be filed with the U.S. Department of Justice, Office of the Special Counsel for Immigration-Related Unfair Employment Practices, 950 Pennsylvania Avenue, NW, Washington, DC, 20530. Please note that complaints should be filed with the Office of Special Counsel at the Department of Justice only if the violation is by an employer who is H-1B dependent or a willful violator as defined in 20 CFR 655.710(b) and 655.734(a)(1)(ii).

O. OMB Paperwork Reduction Act *(1205-0310)*

These reporting instructions have been approved under the Paperwork Reduction Act of 1995. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Obligations to reply are mandatory (Immigration and Nationality Act, Section 212(n) and (t) and 214(c). Public reporting burden for this collection of information, which is to assist with program management and to meet Congressional and statutory requirements is estimated to average 1 hour per response, including the time to review instructions, search existing data sources, gather and maintain the data needed, and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Room C-4312, 200 Constitution Ave. NW, Washington, DC 20210. (Paperwork Reduction Project OMB 1205-0310.) **Do NOT send the completed application to this address.**

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Addendum #1

G. Employment and Prevailing Wage Information

b. Place of Employment 2

1. Address 1 * BUFFALO GENERAL HOSPITAL	
2. Address 2 100 HIGH STREET	
3. City * BUFFALO	4. County * ERIE
5. State/District/Territory * NEW YORK	6. Postal code * 14203

Prevailing Wage Information *(corresponding to the place of employment location listed above)*

7. State Workforce Agency which issued prevailing wage **§** N/A	7a. Prevailing wage tracking number (if provided by SWA) **§** N/A
8. Wage level * ☐ I ☐ II ☐ III ☐ IV ☑ N/A	
9. Prevailing wage * $ 46135.00	10. Per: (Choose only one) * ☐ Hour ☐ Week ☐ Bi-Weekly ☐ Month ☑ Year
11. Prevailing wage source (Choose only one) * ❑ OES ❑ CBA ❑ DBA ❑ SCA ☑ Other	
11a. Year source published * 2011	11b. If "OES" and SWA did not issue prevailing wage **OR** "Other" in question 11, specify source **§** AAMC SURVEY OF RESIDENT/FELLOW STIPENDS AND BENEFITS