



Commonwealth Healthcare Corporation

Commonwealth of the Northern Mariana Islands

1178 Hinemlu' St. Garapan, Saipan, MP 96950



NOTICE OF FILING OF LABOR CONDITION APPLICATION

H-1B non-immigrant workers are being sought by Commonwealth Healthcare Corporation, through the filing of a Labor Condition Application.

Employment Information:

1. Location of Employment:	1178 Hinemlu St. Garapan P. O. Box 500409 Saipan, MP 96950
2. H-1B Job Title:	Nurse Unit Manager
3. Period of Employment:	06/01/2025 – 05/31/2028
4. SOC (ONET/OES) Occupational Classification:	11-9111.00
5. Total # off H-1B Non-immigrant Seeking to Employ:	1
6. Range of Wage Rate Offered (\$):	\$56,301.44 to 62,069.28 per year
7. ETA Case Number:	I-200-25049-700947

Note:

- 1. The labor condition application is available for public inspection at the Human Resources office*
- 2. Complaints alleging misinterpretation of material facts in the labor condition application and/or failure to comply with the terms of the labor condition application may be filed with any office of the Wage and Hour Division of the United States Department of Labor*

In accordance with 20 C.F.R. Part 655.734, this Notice of Filing will be posted for ten (10) consecutive days in two conspicuous locations:

1. Administrative Offices bulletin board
2. Nursing Offices bulletin board

DATE POSTED:

February 27, 2025

DATE CLOSED/REMOVED:

March 09, 2025



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

Please read and review the filing instructions carefully before completing the Form ETA- 9035 or 9035E. A copy of the instructions can be found at <https://www.dol.gov/agencies/eta/foreign-labor/>. 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 (DOL). For all submissions, both electronic (Form ETA- 9035E) or paper (Form ETA- Form 9035 where the employer has notified DOL that it will submit this form non-electronically due to a disability or received permission from DOL to file non-electronically due to lack of Internet access), 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
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B. Temporary Need Information

1. Job Title * Nurse Unit Manager									
2. SOC (ONET/OES) code * 11-9111.00	3. SOC (ONET/OES) occupation title * Medical and Health Services Managers								
4. Is this a full-time position? * <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Period of Intended Employment								
	5. Begin Date * 6/1/2025 <small>(mm/dd/yyyy)</small>								
	6. End Date * 5/31/2028 <small>(mm/dd/yyyy)</small>								
7. Worker positions needed/basis for the visa classification supported by this application									
<table style="width:100%"> <tr> <td style="width:100px"><input type="text" value="1"/></td> <td>Total Worker Positions Being Requested for Certification *</td> </tr> </table> <p>Basis for the visa classification supported by this application <small>(indicate total workers in each applicable category)</small></p> <table style="width:100%"> <tr> <td><input type="text" value="1"/> a. New employment *</td> <td><input type="text" value="0"/> d. New concurrent employment *</td> </tr> <tr> <td><input type="text" value="0"/> b. Continuation of previously approved employment without change with the same employer*</td> <td><input type="text" value="0"/> e. Change in employer *</td> </tr> <tr> <td><input type="text" value="0"/> c. Change in previously approved employment *</td> <td><input type="text" value="0"/> f. Amended petition *</td> </tr> </table>		<input type="text" value="1"/>	Total Worker Positions Being Requested for Certification *	<input type="text" value="1"/> a. New employment *	<input type="text" value="0"/> d. New concurrent employment *	<input type="text" value="0"/> b. Continuation of previously approved employment without change with the same employer*	<input type="text" value="0"/> e. Change in employer *	<input type="text" value="0"/> c. Change in previously approved employment *	<input type="text" value="0"/> f. Amended petition *
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<input type="text" value="0"/> b. Continuation of previously approved employment without change with the same employer*	<input type="text" value="0"/> e. Change in employer *								
<input type="text" value="0"/> c. Change in previously approved employment *	<input type="text" value="0"/> f. Amended petition *								

C. Employer Information

1. Legal business name * Commonwealth Healthcare Corporation		
2. Trade name/Doing Business As (DBA), if applicable		
3. Address 1 * 1178 Hinemlu' St. Garapan		
4. Address 2 P O Box 500409 CK		
5. City * Saipan	6. State * Northern Mariana Islands	7. Postal code * 96950
8. Country * United States Of America		9. Province
10. Telephone number * +1 (670) 236-8202		11. Extension 3554
12. Federal Employer Identification Number (FEIN from IRS) * 66-0774364		13. NAICS code (must be at least 4-digits) * 62211

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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)
Muna	Esther	L.
4. Contact's job title *		
Chief Executive Officer		
5. Address 1 *		
1178 Hinemlu' St. Garapan		
6. Address 2		
P. O. Box 500409 CK		
7. City *	8. State *	9. Postal code *
Saipan	Northern Mariana Islands	96950
10. Country *		11. Province
United States Of America		
12. Telephone number *	13. Extension	14. E-Mail address
+1 (670) 236-8202	3554	chcchr2011@gmail.com

E. Attorney or Agent Information (If applicable)

Important Note: The employer authorizes the attorney or agent identified in this section to act on its behalf in connection with the filing of this application.

1. Is the employer represented by an attorney or agent in the filing of this application? *		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If "Yes," complete the remainder of Section E below.		
2. Attorney or Agent's last (family) name §	3. First (given) name §	4. Middle name(s)
5. Address 1 §		
6. Address 2		
7. City §	8. State §	9. Postal code §
10. Country §		11. Province
12. Telephone number §	13. Extension	14. E-Mail address
15. Law firm/Business name §		16. Law firm/Business FEIN §
17. State Bar number (only if attorney) §		18. State of highest court where attorney is in good standing (only if attorney) §
19. Name of the highest State court where attorney is in good standing (only if attorney) §		



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F. Employment and Wage Information

Important Note: The employer must define the intended place(s) of employment with as much geographic specificity as possible. Each intended place(s) of employment listed below must be the worksite or physical location where the work will actually be performed and cannot be a P.O. Box. The employer must identify all intended places of employment, including those of short duration, on the LCA. 20 CFR 655.730(c)(5). If the employer is submitting 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. An employer has the option to use either a single Form ETA-9035/9035E or multiple forms to disclose all intended places of employment. If the employer has more than ten (10) intended places of employment at the time of filing this application, the employer must file as many additional LCAs as are necessary to list all intended places of employment. See the form instructions for further information about identifying all intended places of employment.

a. Place of Employment Information 1

1. Enter the estimated number of workers that will perform work at this place of employment under the LCA.*	1
2. Indicate whether the worker(s) subject to this LCA will be placed with a secondary entity at this place of employment. *	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. If "Yes" to question 2, provide the legal business name of the secondary entity. §	
4. Address 1 *	
1178 HINEMLU ST GARAPAN	
5. Address 2	
P. O. Box 500409	
6. City *	7. County *
Saipan	Saipan
8. State/District/Territory *	9. Postal code *
Northern Mariana Islands	96950
10. Wage Rate Paid to Nonimmigrant Workers *	10a. Per: (Choose only one)*
From* \$ 56301 . 44 To: \$ 62069 . 28	<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Month <input checked="" type="checkbox"/> Year
11. Prevailing Wage Rate *	11a. Per: (Choose only one)*
\$ 49816 . 00	<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Month <input checked="" type="checkbox"/> Year
Questions 12-14. Identify the source used for the prevailing wage (PW) (check and fully complete only one): *	
<input type="checkbox"/> 12.	A Prevailing Wage Determination (PWD) issued by the Department of Labor
	a. PWD tracking number §
<input type="checkbox"/> 13.	A PW obtained independently from the Occupational Employment Statistics (OES) Program
	a. Wage Level (check one): §
	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> N/A
	b. Source Year §
<input checked="" type="checkbox"/> 14.	A PW obtained using another legitimate source (other than OES) or an independent authoritative source
	a. Source Type (check one): §
	<input type="checkbox"/> CBA <input type="checkbox"/> DBA <input type="checkbox"/> SCA <input checked="" type="checkbox"/> Other/ PW Survey
	b. Source Year §
	2024
	c. If responded "Other/ PW Survey" in question 14.a, enter the name of the survey producer or publisher §
	CNMI Governor's Office
	d. If responded "Other/ PW Survey" in question 14.a, enter the title or name of the PW survey §
	CNMI Governor's Wage Survey



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G. Employer Labor Condition Statements

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

- (1) **Wages:** The employer shall pay nonimmigrant workers at least the prevailing wage or the employer's actual wage, whichever is higher, and pay for non-productive time. The employer shall offer nonimmigrant workers benefits and eligibility for benefits provided as compensation for services on the same basis as the employer offers to U.S. workers. The employer shall not make deductions to recoup a business expense(s) of the employer including attorney fees and other costs connected to the performance of H-1B, H-1B1, or E-3 program functions which are required to be performed by the employer. This includes expenses related to the preparation and filing of this LCA and related visa petition information. 20 CFR 655.731;
- (2) **Working Conditions:** The employer shall provide working conditions for nonimmigrants which will not adversely affect the working conditions of workers similarly employed. The employer's obligation regarding working conditions shall extend for the duration of the validity period of the certified LCA or the period during which the worker(s) working pursuant to this LCA is employed by the employer, whichever is longer. 20 CFR 655.732;
- (3) **Strike, Lockout, or Work Stoppage:** At the time of filing this LCA, the employer is not involved in a strike, lockout, or work stoppage in the course of a labor dispute in the occupational classification in the area(s) of intended employment. The employer will notify the Department of Labor within 3 days of the occurrence of a strike or lockout in the occupation, and in that event the LCA will not be used to support a petition filing with the U.S. Citizenship and Immigration Services (USCIS) until the DOL Employment and Training Administration (ETA) determines that the strike or lockout has ended. 20 CFR 655.733; and
- (4) **Notice:** Notice of the LCA filing was provided no more than 30 days before the filing of this LCA or will be provided on the day this LCA is filed to the bargaining representative in the occupation and area of intended employment, or if there is no bargaining representative, to workers in the occupation at the place(s) of employment either by electronic or physical posting. This notice was or will be posted for a total period of 10 days, except that if employees are provided individual direct notice by e-mail, notification need only be given once. A copy of the notice documentation will be maintained in the employer's public access file. A copy of this LCA will be provided to each nonimmigrant worker employed pursuant to the LCA. The employer shall, no later than the date the worker(s) report to work at the place(s) of employment, provide a signed copy of the certified LCA to the worker(s) working pursuant to this LCA. 20 CFR 655.734.

1. I have read and agree to Labor Condition Statements 1, 2, 3, and 4 above and as fully explained in Section G of the Form ETA-9035CP – General Instructions for the 9035 & 9035E and the Department's regulations at 20 CFR 655 Subpart H. *	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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H. 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 H – Subsection 1 of the Form ETA 9035CP – General Instructions for the 9035 & 9035E under the heading "Additional Employer Labor Condition Statements" and answer the questions below.

a. Subsection 1

1. At the time of filing this LCA, is the employer H-1B dependent? §	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. At the time of filing this LCA, is the employer a willful violator? §	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. If "Yes" is marked in questions H.1 and/or H.2, you must answer "Yes" or "No" regarding whether the employer will use this application <u>ONLY</u> to support H-1B petitions or extensions of status for exempt H-1B nonimmigrant workers? §	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. If "Yes" is marked in question H.3, identify the statutory basis for the exemption of the H-1B nonimmigrant workers associated with this LCA. §	<input type="checkbox"/> \$60,000 or higher annual wage <input type="checkbox"/> Master's Degree or higher in related specialty <input type="checkbox"/> Both
H-1B Dependent or Willful Violator Employers -Master's Degree or Higher Exemptions ONLY	
5. Indicate whether a completed Appendix A is attached to this LCA covering any H-1B nonimmigrant worker for whom the statutory exemption will be based <u>ONLY</u> on attainment of a Master's Degree or higher in related specialty. §	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A



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If you marked "Yes" to questions H.a.1 (H-1B dependent) and/or H.a.2 (H-1B willful violator) and "No" to question H.a.3 (exempt H-1B nonimmigrant workers), you **MUST** read Section H – Subsection 2 of the Form ETA 9035CP – General Instructions for the 9035 & 9035E 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:** An H-1B dependent or willful violator employer is prohibited from displacing a U.S. worker in its own workforce within the period beginning 90 days before and ending 90 days after the date of filing of the visa petition. 20 CFR 655.738(c);
- B. **Secondary Displacement:** An H-1B dependent or willful violator employer is prohibited from placing an H-1B nonimmigrant worker(s) with another/secondary employer where there are indicia of an employment relationship between the nonimmigrant worker(s) and that other/secondary employer (thus possibly affecting the jobs of U.S. workers employed by that other employer), unless and until the employer subject to this LCA makes the inquiries and/or receives the information set forth in 20 CFR 655.738(d)(5) concerning that other/secondary employer's displacement of similarly employed U.S. workers in its workforce within the period beginning 90 days before and ending 90 days after the date of such placement. 20 CFR 655.738(d). Even if the required inquiry of the secondary employer is made, the H-1B dependent or willful violator employer will be subject to a finding of a violation of the secondary displacement prohibition if the secondary employer, in fact, displaces any U.S. worker(s) during the applicable time period; and
- C. **Recruitment and Hiring:** Prior to filing this LCA or any petition or request for extension of status for nonimmigrant worker(s) supported by this LCA, the H-1B dependent or willful violator employer must take good faith steps to recruit U.S. workers for the job(s) using procedures that meet industry-wide standards and offer compensation that is at least as great as the required wage to be paid to the nonimmigrant worker(s) pursuant to 20 CFR 655.731(a). The employer must offer the job(s) to any U.S. worker who applies and is equally or better qualified for the job than the nonimmigrant worker. 20 CFR 655.739.

6. I have read and agree to Additional Employer Labor Condition Statements A, B, and C above and as fully explained in Section H – Subsections 1 and 2 of the Form ETA 9035CP – General Instructions for the 9035 & 9035E and the Department's regulations at 20 CFR 655 Subpart H. §	<input type="checkbox"/> Yes <input type="checkbox"/> No
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I. Public Disclosure Information

! Important Note: You must select one or both of the options listed in this Section.

1. Public disclosure information in the United States will be kept at: *	<input type="checkbox"/> Employer's principal place of business <input checked="" type="checkbox"/> Place of employment
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J. Notice of Obligations

- A. Upon receipt of the certified LCA, the employer must take the following actions:
 - o Print and sign a hard copy of the LCA if filing electronically (20 CFR 655.730(c)(3));
 - o Maintain the original signed and certified LCA in the employer's files (20 CFR 655.705(c)(2); 20 CFR 655.730(c)(3); and 20 CFR 655.760); and
 - o Make a copy of the LCA, as well as necessary supporting documentation required by the Department of Labor regulations, available for public examination in a public access file at the employer's principal place of business in the U.S. or at the place of employment within one working day after the date on which the LCA is filed with the Department of Labor (20 CFR 655.705(c)(2) and 20 CFR 655.760).
- B. The employer must develop sufficient documentation to meet its burden of proof with respect to the validity of the statements made in its LCA and the accuracy of information provided, in the event that such statement or information is challenged (20 CFR 655.705(c)(5) and 20 CFR 655.700(d)(4)(iv)).
- C. The employer must make this LCA, supporting documentation, and other records available to officials of the Department of Labor upon request during any investigation under the Immigration and Nationality Act (20 CFR 655.760 and 20 CFR Subpart I).

I declare under penalty of perjury that I have read and reviewed this application and that to the best of my knowledge, the information contained therein is true and accurate. I understand that to knowingly furnish materially false information in the preparation of this form and any supplement thereto or to aid, abet, or counsel another to do so is a federal offense punishable by fines, imprisonment, or both (18 U.S.C. 2, 1001, 1546, 1621).

1. Last (family) name of hiring or designated official * Muna	2. First (given) name of hiring or designated official * Esther	3. Middle initial § L.
4. Hiring or designated official title * Chief Executive Officer		
5. Signature * 		6. Date signed * 02/24/2025

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K. LCA Preparer

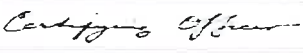
Important Note: Complete this section if the preparer of this LCA is a person other than the one identified in either Section D (employer point of contact) or E (attorney or agent) of this application.

1. Last (family) name § Tudela	2. First (given) name § Vanessa	3. Middle initial DLG
4. Firm/Business name § Commonwealth Healthcare Corporation		
5. E-Mail address § vanessa.tudela@chcc.health		

L. 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 6/1/2025 to 5/31/2028.


Department of Labor, Office of Foreign Labor Certification

2/24/2025
Certification Date (date signed)

I-200-25049-700947
Case number

Certified
Case Status

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

M. 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 DOL before it can be submitted to USCIS for final 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, U.S. Department of Labor. A listing of the Wage and Hour Division offices can be obtained at www.dol.gov/whd. 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, Civil Rights Division, Immigrant and Employee Rights Section, 950 Pennsylvania Avenue, NW, # IER, NYA 9000, Washington, DC, 20530, and additional information can be obtained at www.justice.gov. Please note that complaints should be filed with the Civil Rights Division, Immigrant and Employee Rights Section 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).

For public burden statement information, please see Form ETA-9035CP General Instructions.