MISSISSIPPI STATE DEPARTMENT OF HEALTH

MISSISSIPPI NATIONAL INTEREST WAIVER PROGRAM APPLICATION

The employment based second-preference Worker Visa Preference Category (EB-2) allows individuals of exceptional ability and individuals who are members of professions holding advanced degrees to obtain a green card (United States permanent residence). For EB-2s a job offer and a labor certification is generally required. This requirement can be waived if the petitioner demonstrates to the United States Citizen and Immigration Services (USCIS) that granting the EB-2 petition would be in the national interest of the United States. The Physician National Interest Waiver (NIW) may be granted by the USCIS to a physician that agrees to work for a period of five (5) years in a designated underserved area.

All requests for consideration of a National Interest Waiver support letter must at a minimum meet the following federal eligibility criteria:

1. Physicians must agree to work full-time in a clinical practice for a period of five (5) years.
2. Physician must work in primary care (such as general practitioner, family practitioner, general internist, pediatrician, obstetrician/gynecologist, or psychiatrist) or be a specialty physician.
3. Physician must serve either in a currently designated Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or for specialists, in a Physician Scarcity Area (PSA).
4. Physician must obtain a statement from a federal agency or a state department of health that has knowledge of the physician's qualifications and states that the physician's work is in the public interest.

Facilities and physicians interested in requesting consideration for support letters for NIWs must submit the information listed in items A through P of the NIW application to the Mississippi State Department of Health.

MISSISSIPPI NATIONAL INTEREST WAIVER PROGRAM APPLICATION
Application Information

Please submit one (1) original and one (1) hard copy of the completed application to the Mississippi Office of Rural Health and Primary Care (MORHPC) via postal address.

Please include a table of contents and separate each section by alphabetical dividers. Please do not use staples, binders, metal clamps, two-sided copies, and/or pages smaller than 8.5 x 11 inches. Please use a rubber band to separate each copy.

The application should be mailed to the following address:

Judy Newton, Director
Office of Rural Health and Primary Care
Mississippi State Department of Health
Post Office Box 1700
Jackson, Mississippi 39215-1700

If you have any questions, please email physicianvisawaiver@msdh.ms.gov.

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Application Exhibit Section

Requests for NIW support letters must include the following in the order listed:

A. A letter from the employing medical facility indicating (on the employing medical facility's official letterhead):

1) That the sponsoring medical facility is supporting a NIW application and is requesting a support letter from the Mississippi State Department of Health.
2) The name of the proposed physician, medical discipline, and information on physician's qualifications.
3) The name and location (complete street address, 9-digit zip code, and county) of the practice site(s) where the proposed physician will complete the five (5) year full-time clinical practice service obligation.
4) The name of the currently designated Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or Physician Scarcity Area (PSA) for specialist, where the proposed physician will serve.
5) A description of the public benefit to the community that approval of the NIW will provide.

B. The Mississippi State Department of Health NIW Sponsoring Medical Facility Information Sheet. The following should be provided on the sheet:

1) Date, Name of Sponsoring Medical Facility, Complete Street and Mailing Address, Phone and Fax
2) Name of Chief Executive Official
3) Application Contact Person and Contact Information
4) Check type of services provided
5) Check Organization Profit, Non-profit, Public status
6) Check Practice Type
7) Provide Medicaid and Medicare Numbers

C. The Mississippi State Department of Health NIW Practice Site Information Sheet. A separate sheet should be completed for each practice site. The following should be provided on the sheet.

1) Name of Practice Site, Complete Street and Mailing Address, Phone and Fax
2) Indicate how long site has been operational
3) Indicate if practice site is located in a federally designated primary care Health Professional Shortage Area (HPSA)
4) Indicate if practice site is located in a Physician Scarcity Area (PSA) for specialists
5) Indicate if practice site is located in a federally designated mental Health Professional Shortage

Area (HPSA)

6) Provide utilization data for previous calendar year

D. The Mississippi State Department of Health NIW Physician Information Sheet. The following should be provided on the sheet.

1) Department of State Case Number
2) Name, Complete Street and Mailing Address, Phone Numbers (Home and Cell), Email Address
3) Medical Discipline
4) Home Country
5) Residency, Medical School, Fellowship (if applicable) Educational Information
6) Mississippi State Medical Licensure Information

E. A copy of notarized, dated, executed employment contract to meet the five (5) year full-time employment service obligation required by the NIW regulations.
F. A letter of support from the current or previous employer of the physician or from a health care professional who has knowledge of the physician's qualifications.
G. A letter from the sponsoring medical facility indicating that the organization: **1)** understands that the NIW requires the physician to meet a five (5) year full-time clinical practice service obligation; and **2)** that the organization agrees to submit the annual MSDH NIW Physician Employment Verification Form
H. A letter from the applying physician indicating that the physician: **1)** agrees to meet the requirement of the NIW of a five (5) year full-time clinical practice service obligation; and **2)** agrees to submit the annual MSDH NIW Physician Employment Verification Form.
I. If the physician seeking the NIW support letter currently has a waiver from the two-year home residence requirement and has not completed the waiver's three (3) year full-time federal and contractual service obligation, the physician and the NIW sponsoring medical facility must both submit individual letters indicating that they understand and agree that the a physician must meet the waiver's three (3) year full-time federal and contractual service obligation of the employment contract entered, as PL 106-95 does not change the physician's obligation of the waiver contract terms. The letters must include the start and ending dates of the waiver service obligation period.
J. Physician's Curriculum Vitae.
K. Copy of a passport-style photo of physician.
L. Copy of physician's medical degree.
M. Proof of physician's passage of United States Medical Licensing Examinations (USMLE 3 Steps).
N. Copy of physician's Educational Commission for Foreign Medical Graduates Certificate.
O. Documentation of proposed physician's Board Certification or Board eligibility status.
P. Copy of physician's Mississippi Medical License or documentation that application is in process.

MISSISSIPPI STATE DEPARTMENT OF HEALTH

MISSISSIPPI NATIONAL INTEREST WAIVER PROGRAM APPLICATION
Section A – Cover Letter

Please submit a cover letter to the Mississippi State Department of Health, Office of Rural Health and Primary Care. The cover letter should be on the organization's letterhead and must include theinformation below in the order listed.

Date

MORHPC Director's Name
Mississippi Office of Rural Health and Primary Care
MS State Department of Health Post Office Box 1700
Jackson, MS 39215-1700

Dear Director:

1. A statement indicating that the sponsoring medical facility (indicate type of facility, i.e., hospital,FQHC, clinic) is supporting a NIW application through the National Interest Waiver Program for a [identify specific medical discipline] physician and is requesting a letter of support from the Mississippi State Department of Health.

2. The name of the proposed NIW physician, medical discipline, and information on the physician's qualifications and duties.

3. The name of the sponsoring medical facility, its complete street address (including 9-digit zip code, and county location.

4. The name and location (complete address, 9-digit zip code, and county) of the practice site(s) where the prospective NIW physician will complete the full-time service obligation. (if different from #3 above).

5. The name of the Health Professional Shortage Area (HPSA) to be served.

6. A description of the public benefit to the community that approval of the NIW will provide.

7. A statement that the facility is offering the applying J-1 Visa physician, at a minimum, a three- year employment contract to work 40 hours per week as a primary care physician, psychiatrist, ormedical specialist to provide health care services for residents of [name the HPSA(s)].

MISSISSIPPI STATE DEPARTMENT OF HEALTH

MISSISSIPPI NATIONAL INTEREST WAIVER PROGRAM APPLICATION
Section B – Sponsoring Medical Facility Information Sheet

Name of Sponsoring Medical Facility _____

Street Address _____

PO Box _____

City _____ **9-Digit Zip Code** _____

County _____

Phone Number _____

Name of Chief Executive Official _____

Contact Person for Application _____

Phone Number _____ **Email** _____

Nature of the primary care services to be provided full time by applying J-1 Visa physician:

□ **Family Practice** □ **General Practice** □ **General Internal Medicine**
□ **Pediatrics** □ **Psychiatry** □ **Obstetrics and Gynecology**
□ **Specialist (specify)** _____

Please Check: □ **Private Not-For-Profit** □ **Private For-Profit** □ **Public Not-For-Profit**

Type of Practice (select all that apply):

□ **Federally Qualified Health Center** □ **Rural Health Clinic** □ **Free Clinic**
□ **Critical Access Hospital** □ **Outpatient/Ambulatory**
□ **National Health Service Corps Site** □ **Public Health Department**
□ **Federally Qualified Health Center Look-Alike** □ **Community Mental Health Agency**
□ **Other (specify)** _____

Medicaid # _____ **Medicare #** _____

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Section C – Practice Site Information Sheet

Please label this section C. A separate sheet must be completed for each Practice Site (make copies if needed).

Name of Practice Site _____

Street Address _____

PO Box _____

City_____ 9-Digit Zip Code_____

Phone Number_____ County _____

1. How long has this site been operational?_____ (Years)
2. If the application is for a primary care physician, is this practice site located in a federally designated primary care Health Professional Shortage Area (HPSA)? ☐Yes ☐No
3. If the application is for a psychiatrist, is this practice site located in a federally designated Mental HealthProfessional Shortage Area (HPSA)? ☐Yes ☐No
4. Is there a Hospital/Provider Referral Arrangement for this physician? ☐Yes ☐No
5. Is there a Hospital Admission Agreement for this physician? ☐Yes ☐No

Provide data for public service rendered at this practice site for previous calendar year
Patient breakdown by primary payer source for this reporting period (total should equal 100%):

a. Total Number of Unduplicated Patients _____ %

b. Medicare _____ %

c. Medicaid _____ %

d. SCHIP Patients _____ %

e. Private Insurance _____ %

f. Sliding Fee Scale Patients _____ %

g. Self-Pay / No Insurance %

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Section D – Applying Physician Information Sheet

Department of State Number_____ **National Provider Identifier**_____

Name (Last)_____(First)_____M.I.___

Home Telephone #_____Office #_____ Cell Phone #_____

Email_____

Street Address _____

PO Box _____ City _____ State _____ Zip Code

_____

EDUCATIONAL INFORMATION

Residency Program:

Training Discipline _____

Name of Institution _____

Location of Institution _____

Graduation Date_____If not complete, expected completion date: _____

Certifications Held _____

Medical School Education:

Name of Institution _____

Location_____

Graduation Date _____

Fellowship Training (if applicable):

Training Discipline _____

Name of Institution _____

Location_____

Graduation Date_____If not complete, expected completion date: _____

Certifications Held _____

MISSISSIPPI MEDICAL LICENSURE INFORMATION

Has the physician received a Mississippi Medical License? ☐Yes ☐No

If not, has the physician applied for Mississippi Medical License? ☐Yes ☐No