



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 are generally required. This requirement can be waived if the petitioner demonstrates to the United States Citizenship 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 who agrees to work for 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 five (5) years.
2. Physicians must work in primary care (such as general practitioners, family practitioners, general internists, pediatricians, obstetrician/gynecologists, or psychiatrists) or be a specialty physician.
3. Physicians 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. The 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 STATE DEPARTMENT OF HEALTH

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Please submit an electronic copy of the completed application to the Mississippi Primary Care Office (PCO) via our secure electronic portal. You can find our electronic application link located at msdh.ms.gov.

Using the link, complete the form in its entirety before uploading the application documents to the Smartsheet portal.

Please include a table of contents and adhere to the 'Application Exhibit Section' located within the application packet. The DOS File Number must be included on all pages.

Only the application fee should be mailed to the following address:

**Richard Calderone, Director
Mississippi Primary Care Office
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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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 supports 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 the 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 specialists, 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 the 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 the site has been operational
3. Indicate if the practice site is in a federally designated primary care Health Professional Shortage Area (HPSA)
4. Indicate if the practice site is in a Physician Scarcity Area (PSA) for specialists
5. Indicate if the practice site is in a federally designated Mental Health Professional Shortage Area (HPSA)
6. Provide utilization data for the 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 a 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 knows the physician's qualifications.

G.) A letter from the sponsoring medical facility indicating that the organization:

- Understands that the NIW requires the physician to meet a five (5) year full-time clinical practice service obligation; and
- The organization agrees to submit the annual MSDH NIW Physician Employment Verification Form

H.) A letter from the applying physician indicating that the physician:

- Agrees to meet the requirement of the NIW of a five (5) year full-time clinical practice service obligation; and
- 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 end dates of the waiver service obligation period.

J.) Physician's Curriculum Vitae.

K.) Copy of a passport-style photo of the physician.

L.) Copy of the physician's medical degree.

M.) Proof of the physician's passage of the United States Medical Licensing Examinations (USMLE)

N.) Copy of the physician's Educational Commission for Foreign Medical Graduates Certificate.

O.) Documentation of the proposed physician's Board Certification or Board eligibility status.

P.) Copy of the physician's Mississippi Medical License or documentation that the application is in process.



MISSISSIPPI NATIONAL INTEREST WAIVER PROGRAM APPLICATION
Section A – Cover Letter

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

Date

PCO Director’s Name
Mississippi Primary Care Office
Mississippi State Department of Health
Post Office Box 1700 Jackson, MS 39215-1700

Dear Director:

1. A statement indicates 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 an [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 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, or medical specialist to provide health care services for residents of [name the HPSA(s)].



**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 # _____



**MISSISSIPPI NATIONAL INTEREST WAIVER PROGRAM APPLICATION
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 Health Professional 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 the 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 _____ %



**MISSISSIPPI NATIONAL INTEREST WAIVER PROGRAM APPLICATION
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