MISSISSIPPI STATE DEPARTMENT OF HEALTH

TO: Prospective NIW Physician Employers/Sponsors

FROM: Director, Mississippi Office of Rural Health and Primary Care

RE: Mississippi Conrad State 30 J-1 Visa 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 NIW support letter must at a minimum meet the following federal eligibility criteria:

1. Physician 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 a 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 R of the NIW Application to the Mississippi State Department of Health.

Mississippi State Department of Health
NATIONAL INTEREST WAIVER APPLICATION

Facilities and physicians interested in requesting consideration for support letters for NIWs must submit the information listed below in items A through R to the Mississippi State Department of Health. Please submit one (1) original and two (2) copies of the information required. Include a table of content 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.**

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):

i. That the sponsoring medical facility is supporting a NIW application and is requesting a support letter from the Mississippi State Department of Health.

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

iii. 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.

iv. 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.

v. 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:

i. Date, Name of Sponsoring Medical Facility, Complete Street and Mailing Address, Phone and Fax

ii. Name of Chief Executive Official

iii. Application Contact Person and Contact Information

iv. Check type of services provided

v. Check Organization Profit, Non-profit, Public status

vi. Check Practice Type

vii. 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.

i. Name of Practice Site, Complete Street and Mailing Address, Phone and Fax
ii. Indicate how long site has been operational
iii. Indicate if practice site located in a federally designated primary care Health Professional Shortage Area (HPSA)
iv. Indicate if practice site located in a Physician Scarcity Area (PSA) for specialists
v. Indicate if practice site is located in a federally designated mental Health Professional Shortage Area (HPSA)
vi. 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.

i. Department of State Case#
ii. Name, Complete Street and Mailing Address, Phone Numbers (Home and Cell), Email Address
iii. Medical Discipline
iv. Home Country
v. Residency, Medical School, Fellowship (if applicable) Educational Information
vi. Mississippi State Medical Licensure Information

E. A HIV test result and evidence of screening for latent and active tuberculosis for the applying physician. The tuberculosis screening must include: a tuberculosis signs and symptom assessment by a licensed physician or nurse practitioner; testing for infection performed by an interferon gamma release assay (IGRA) when reasonably available or a Mantoux tuberculin skin test (TST) when the IGRA is not available; and a chest x-ray with a written interpretation. Both the HIV test result and tuberculosis screening must have occurred within the past 6 months prior to the submission date of the waiver request, with the exception, of the IGRA and TST if documentation of current or previous tuberculosis treatment completion is provided with the submission. A MSDH approved plan for treatment and an approved provision for payment of testing, treatment, and follow-up for a foreign physician showing signs of active tuberculosis (not required if applying physician received a J-1 Visa waiver through the MSDH within the past 12 months).

F. A copy of notarized, dated, executed employment contract to meet the five (5) year full-time employment service obligation required by the NIW regulations.

G. 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.

H. 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.

I. 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.

J. 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.

K. Physician's Curriculum Vitae.

L. Copy of physician's Social Security Card.

M. Copy of a passport-style photo of physician.

N. Copy of physician's medical degree.

O. Proof of physician's passage of United States Medical Licensing Examinations (USMLE 3 Steps).

P. Copy of physician's Educational Commission for Foreign Medical Graduates Certificate.

Q. Documentation of proposed physician's Board Certification or Board eligibility status.

R. Copy of physician's Mississippi Medical License or documentation that application in process.

MISSISSIPPI STATE DEPARTMENT OF HEALTH

NATIONAL INTEREST WAIVER
SPONSORING MEDICAL FACILITY INFORMATION SHEET

Date ____

Name of Sponsoring Medical Facility _______________________________________

Street Address____

PO Box ____

City ___________________________ 9-Digit Zip Code__________________

County ____

Phone Number ____________________ Fax Number _____________________

Name of Chief Executive Official __________________________________

Contact Person for Application ___________________________________

Phone Number ____________________ Fax 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 (list) ____

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 Federally Qualified Health Center Look-Alike

Community Mental Health Agency Public Health Department

Other (list) ____

Medicaid #: ____

Medicare #: ____

Mississippi State Department of Health

NATIONAL INTEREST WAIVER
PRACTICE SITE INFORMATION SHEET

A separate Sheet must be used for each Practice Site (make copies if needed).

Name of Practice Site ____

Street Address ____

PO Box ____

City __________________________ 9-Digit Zip Code_______________

Phone Number ____________________ Fax Number ___________________

County ____

How long has this site been operational? ____________ Years

If application for a primary care physician, is this practice site located in a federally designated primary care Health Professional Shortage Area (HPSA)? Yes _____ No _____

If application for a specialist, is this practice site located in a federally designated primary care Health Professional Shortage Area (HPSA)? Yes _____ No _____

If application for a psychiatrist, is this practice site located in a federally designated mental Health Professional Shortage Area (HPSA)? Yes _____ No _____

Is there a Hospital/Provider Referral Arrangement for this physician? Yes _____ No _____

Is there a Hosptial Admission Agreement for this physician? Yes _____ No _____

Provide Data for Public Service Rendered At This Practice Site Previous Calendar Year

	Previous Calendar Year Data
Total # of Unduplicated Patients	
% Medicaid Patients	
% Medicare Patients	
% SCHIP Patients	
% Private Insurance Patients	
% Sliding Fee Scale Patients	
% Other	

NATIONAL INTEREST WAIVER
PHYSICIAN INFORMATION SHEET

Department of State Case# ____

Name (Last) ______________________ (First)______________________ M.I.___

Home Telephone # ____________________ Office # ______________________

Cell Phone # ________________ Email ________________________________

CURRENT MAILING ADDRESS

Street Address ____

PO Box ____

City ____________________________ State _______ Zip Code _____________

Medical Discipline _________________ Subspecialty _______________________

Home Country ________________________ Date of Birth ______________

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 Mississippi Medical License? Yes ___ No ____

If No, has the physician applied for Mississippi Medical License? Yes ____ No ____

Mississippi State Department of Health
NATIONAL INTEREST WAIVER APPLICATION

The Mississippi State Department of Health NIW Application should be mailed to the following address:

Rozelia Harris, 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 contact Kara Aldridge at 601-576-7216.