

NATIONAL INTEREST WAIVER PHYSICIAN VERIFICATION OF EMPLOYMENT FORM

SECTION I

PHYSICIAN NAME: _____
Please Print

EMPLOYMENT START DATE AT SPONSORING MEDICAL FACILITY: _____

INS J-1 Visa Waiver Approval Date: _____ H-1B Visa Approval Date: _____

PHYSICIAN'S HOME ADDRESS: _____

Street _____ City _____ State _____ Zip Code: _____

Email: _____

Home Phone: _____ CELL Phone: _____

SECTION II PRACTICE SITE INFORMATION

| | |
|------------------|------------------|
| Name Site 1: | Name Site 2: |
| Street Address: | Street Address: |
| City, State, ZIP | City, State, ZIP |
| Site Phone #: | Site Phone #: |

SECTION III

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE OR SPECIALITY CARE (IF APPROVED AS SPECIALIST) AT THE ABOVE STATED SITE(S) A MINIMUM OF 40 HOURS PER WEEK.

Physician's Signature

Date

SECTION IV

THIS SECTION TO BE COMPLETED AND SIGNED BY SPONSORING MEDICAL FACILITY:

I HEREBY CERTIFY THAT DOCTOR _____

(Please Check Below As Applicable)

IS WORKING AT SITE(S) LISTED IN SECTION II AND IS IN YEAR _____ OF THE FIVE YEAR SERVICE OBLIGATION

HAS COMPLETED SERVICE OBLIGATION AND *STILL* AT SITE(S) LISTED IN SECTION II

HAS COMPLETED SERVICE OBLIGATION AND NO LONGER AT SITE(S) LISTED IN SECTION II

DID NOT COMPLETE SERVICE OBLIGATION

TRANSFERRED

WILL START ON _____ AT SITE(S) LISTED IN SECTION II

Printed Name of Sponsoring Medical Facility Representative

Signature of Sponsoring Medical Facility Representative

Date

(THIS FORM MUST BE NOTARIZED)

RETURN THIS FORM BY MAIL TO:
 Mississippi State Department of Health
 ATTN: Director, Office of Rural Health & Primary Care
 570 East Woodrow Wilson - P. O. Box 1700
 Jackson, Mississippi 39215-1700

**NATIONAL INTEREST WAIVER PHYSICIAN VERIFICATION OF
EMPLOYMENT FORM**

Form #632E

(Form located on the Primary Care page of the website)

PURPOSE

The purpose of this form is to verify the employment status of National Interest Waiver Physicians issued support letters from the Mississippi State Department of Health. The physicians are required to work five years at the sponsoring medical facility approved practice site(s).

INSTRUCTIONS

*National Interest Waiver Physicians issued support letters from the Mississippi State Department of Health and a representative of the medical facility sponsoring the National Interest Waiver Physician should complete and submit the form to the Primary Care Office (PCO) once the physician begins employment with the sponsoring medical facility and annually thereafter. The PCO will mail the form to the National Interest Physicians in the PCO database. **This Form Must Be Notarized.***

The following should be provided on the form:

Section I

National Interest Waiver Physician should provide contact information in Section I. Information includes physician name, complete home address, home telephone number, cell phone number, and email address.

In Section I, National Interest Waiver Physician should also provide approval date of J-1 VISA Waiver and/or H-1B.

Section II

National Interest Waiver Physician should provide the following for the sponsoring medical facility practice site(s): facility name, complete address, and telephone number.

Section III

National Interest Waiver Physician needs to certify working 40 hours per week providing health care services at medical facility practice site(s) listed in Section II.

Section IV

Representative of sponsoring medical facility must certify that National Interest Waiver Physician is or is not working at practice site(s) listed in Section II.

Revised 01/05/2012