New Hampshire National Interest Waiver
Physician & Employer Information Sheet

Physician Information

Please type or print:

Name: _____ Date of Birth: _____
Last First Middle

Address: _____

Mailing Address if Different from above: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Start Date of J-1 Visa Waiver: _____

End Date of Three-Year Commitment: _____

Please Check Your Discipline:

Family Practice Pediatrics Obstetetrics/Gynecology Internal Medicine
Psychiatry Hospitalist Geriatrics Other Explain: _____

Please Check Your Designation Area

HPSA MHPSA MUA MUP EMUP

Are you NH Board Certified? Yes No Expiration Date: _____

If you answered yes to any of these questions below, attach an explanation to the application

Has your medical/certification license ever been suspended or revoked? YES NO

Are any professional disciplinary actions pending? YES NO

Have you ever been convicted or pled guilty to a felony as so defined under either Federal or State laws?
YES NO

Employer Information

Employer Name: _____ Practice Name: _____

Primary Practice Site: _____

Days/week: _____ Hours/week: _____

Sliding-Fee-to-Schedule in Place: Yes No

If No explain: _____

_____

This facility accepts Medicaid, Medicare, uninsured, and underinsured patients? Yes No

If No explain: _____

_____

Practice Address: _____

Town: _____ State: _____ Zip: _____ County: _____

Secondary Practice Address: _____

Town: _____ State:_____ Zip:_____ County:_____

Contact Person: _____Title: _____
Administrator or HR Director

Phone: _____Fax: _____E-Mail: _____