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Physician’s Affidavit and Agreement

National Interest Waiver (NIW) Program

I, (print name) _____, hereby request the New Hampshire Department of Health & Human Services (NHDHHS) to review my application for the purpose of recommending approval of my National Interest Waiver by assurance of a formal “Letter of Attestation”, pursuant to the terms and conditions as follows:

I understand and acknowledge that NH Division of Public Health Services (DPHS), Rural Health Primary Care Section (RHPC) reserves the right to deny support of a National Interest Waiver. DPHS, RHPC does not bear any liability for the denial of support of a National Interest Waiver application, which includes, but is not limited to, the consequences arising from any practice arrangements or contracts entered into by the J-1 physician or proposed employer before or after requesting any New Hampshire National Interest Waiver recommendation.

I further understand and acknowledge that the entire basis for the consideration of my request is the State of New Hampshire’s voluntary policy and desire to improve the availability of primary medical care in areas designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs), Mental Health Professional Shortage Areas (MHPSAs), Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs), or Exceptional Medically Underserved Population Areas (E-MUPs).

I understand and agree that in consideration for a “Letter of Attestation”, which eventually may or may not be granted, I shall render primary medical care services to patients, including the indigent, for a minimum of forty (40) hours per week within the HRSA designated HPSAs, MHPSAs, MUAs, MUPs, or E-MUPs located in New Hampshire.

I understand that if I am a primary care physician with sub-specialty or fellowship training that I am prohibited from practicing sub-specialty services during my required 40 hours per week of primary care services. I further certify that I have following credentials and will engage in the following practice: _____

If my termination occurs before fulfilling the minimum three or five year service requirement, as application to my J-1 Visa Waiver or National Interest Waiver, I will notify the RHPC Workforce Program Assistant immediately.

In the event of a transfer to another employer or practice location(s), a formal transfer notification request must be submitted to the RHPC under the guidelines established by J-1 visas for such actions.

I understand that I must provide medical services to all patients regardless of their ability to pay. In addition, the employer and/or service site(s) must offer a sliding-fee-schedule based on current [Federal Poverty Guidelines](#), accept Medicaid, Medicare and provide free care when medically necessary.

I declare that I do not have pending nor am I submitting during the decision of this request, another request to any US Government department or agency or any State Department of Public Health, or equivalent, other than the State of New Hampshire Department of Public Health Services to act on my behalf in any matter relating to my National Interest Waiver.

I understand and acknowledge that if I willfully fail to comply with the terms of this NH Physician Affidavit and Agreement, the DPHS will notify the USCIS of the breach which could result in deportation proceedings being instituted against me. Additionally, any and all measures available to the DPHS will be taken in the event of non-compliance.

