



**STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN  
SERVICES**

29 HAZEN DRIVE, CONCORD, NH 03301-6527  
603-271-4741 1-800-852-3345 Ext. 4741  
Fax: 603-271-4506 TDD Access: 1-800-735-2964



**New Hampshire National Interest Waiver (NIW)**

**J-1 Physician & Employer Information**

**Please type or print:**

**Physician Information**

- 1) Physician Name: \_\_\_\_\_ Practice/Specialty: \_\_\_\_\_
- 2) Birth Date: \_\_\_\_\_
- 3) Home Address: \_\_\_\_\_
- 4) Practice Site Address: \_\_\_\_\_
- 5) Home Ph#: \_\_\_\_\_ Work PH#: \_\_\_\_\_ E-Mail: \_\_\_\_\_
- 6) J-1 Visa Waiver Employment Start Date: \_\_\_\_\_ J-1 Visa Waiver Employment End date: \_\_\_\_\_
- 7) NIW Employment Start Date: \_\_\_\_\_ NIW Employment End Date: \_\_\_\_\_
- 8) Enter daily office hours (include administrative time, (do not include time traveled or time spent on call)

Day	Time (Start and End)		Day	Time (Start and End)	
Monday	AM:	PM:	Tuesday	AM:	PM:
Wednesday			Thursday		
Friday			Saturday		
Sunday					

Enter office hours if working split schedule at practice site:

Day	Time (Start and End)		Day	Time (Start and End)	
Monday	AM:	PM:	Tuesday	AM:	PM:
Wednesday			Thursday		
Friday			Saturday		
Sunday					

9) 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

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Employer Information**

1) Describe your payor mix in the last 6 months as % of revenue, where the J-1 physician is working?

- Medicaid: \_\_\_\_ %
- Medicare: \_\_\_\_ %
- State's Children Health Program: \_\_\_\_ %
- Underinsured (sliding-fee-schedule): \_\_\_\_ %
- Bad/debit charity: \_\_\_\_ %
- Other: \_\_\_\_%

2) Has the J-1 physician maintain the appropriate New Hampshire Medical License under this agreement and conform to all State laws and administrative rules pertaining to profession being practiced. YES  NO  If yes, please **explains:** \_\_\_\_\_

3) Has any restrictions that would enable this J-1 physician from doing his/her duties at the practice site been applied to the J-1 physician by the employer? **YES**  **NO**  **If Yes, Please explain:**  
\_\_\_\_\_  
\_\_\_\_\_

4) This facility accepts Medicaid, Medicare, uninsured, and underinsured patients?  Yes  No  
If No explain: \_\_\_\_\_

5) Does the practice site have a Sliding-Fee-Schedule in place?  Yes  No If no, please explain:  
\_\_\_\_\_

Authorization Employer's Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Work Ph# \_\_\_\_\_ E-mail: \_\_\_\_\_ Fax #: \_\_\_\_\_

I do hereby certify that Doctor \_\_\_\_\_ is employed by \_\_\_\_\_  
\_\_\_\_\_, Address \_\_\_\_\_

and provides 40 hours of primary care services per week.

**Authorization Employer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_