Bureau for Public Health
Office of Community Health Systems and
Health Promotion WV State Office of Rural Health
350 Capitol Street, Room 515
Charleston, West Virginia 25301-3716

NATIONAL INTEREST WAIVER GUIDELINES

A physician requesting attestation letter from the West Virginia Bureau for Public Health, Office of Community Health Systems and Health Promotion, West Virginia State Office of Rural Health (Division of Rural Health and Recruitment) must complete the National Interest Waiver (NIW) Application. The Physician will be notified in writing of the approval or denial of the request. If the request is approved, an attestation letter will be provided to the physician. If denied, a letter will be provided outlining the reason(s) the request was not approved.

The Physician must:

1. Work full-time (40 hours per week) in a clinical practice located in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA) (as defined by the United States Public Health Service) within the State of West Virginia for **five** years (not including time in J-1 non-immigrant status).

2. Practice full time (40 hours per week) in a **primary care and Specialty** (family or general medicine, general internal medicine, pediatrics, obstetrics/gynecology or psychiatry).

3. Practice in the public interest. In West Virginia, this is defined as serving underinsured or uninsured patients as evidenced by acceptance of Medicaid, Medicare and use of a sliding/discounted fee scale for those without insurance.

4. Sign and adhere to the West Virginia National Interest Waiver Affidavit and Agreement.

5. Must have worked in West Virginia for six months prior to requesting attestation letter.

6. Provide an application cover letter from the employer to include the following:

   a. Physician's name and medical specialty
   b. Date employment began
   c. Assurances the physician has worked 40 hours a week in the underserved area, accepts Medicare, Medicaid, uninsured patients and utilizes a sliding/discounted fee schedule for those patients that are unable to pay, and has a posted notice regarding these charges.

7. Provide an amended employment contract to cover the five-year requirement.

8. ALIEN (A)# and/or RECEIPT (SRC)#

9. An affirmation statement that physician is able to practice medicine and is not under disciplinary review or a letter from board stating that the physician is in good standing.

10. Copy of physician's current WV medical license.

Attachments:
1. Letter from employer supporting the NIW
2. Employment Contract to cover 5-year period
3. Signed and notarized West Virginia NIW Affidavit and Agreement
4. ALIEN (A)# and/or RECEIPT (SRC)#
5. WV Medical License
6. Proof physician is good stand to practice.

Bureau for Public Health
Office of Community Health Systems and
Health Promotion WV State Office of Rural Health
350 Capitol Street, Room 515
Charleston, West Virginia 25301

NATIONAL INTEREST WAIVER AFFIDAVIT AND AGREEMENT

BEFORE ME, the undersigned authority, personally appeared _____, who after being dully sworn deposes:

1. My name is _____. I have requested the West Virginia Department of Health (WVDH), Bureau for Public Health (BPH), Office of Community Health Systems and Health Promotion (OCHSHP), Division of Rural Health and Recruitment (DRHR) to review my request for an attestation letter in support of a National Interest Waiver (NIW). I understand and acknowledge that the review of this request is discretionary and that in the event a decision is made not to grant my request, I hold the State of West Virginia, DH, its employees and/or any and all individuals or organizations involved in the review process harmless from any action or lack of action made in connection with this request.

2. I further understand the and acknowledge that the entire basis for the consideration of my request is voluntary participation and mission to increase the availability of medical care in areas designated by the Secretary of the U.S. Department of Health and Human Services as a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA) in the State of West Virginia.

3. I understand and agree that in consideration for an attestation letter, I shall render clinical medical care services to patients, including the underserved, for a minimum of forty (40) hours per week within a designated HPSA or MUA in West Virginia.

4. I agree to provide medical care to individuals without discrimination against them because (a) they are unable to pay for those services or (b) payment for those health services will be made under Medicaid or Medicare. I will charge persons receiving services at the usual and customary rate prevailing in the HPSA or MUA in which services are provided, except persons at or below 200 percent of the federal poverty level as determined annually by the U. S. Department of Health and Human Services, shall be charged on a discounted or sliding fee schedule or shall not be charged if they are unable to pay for these services.

5. I expressly agree that relocation from a site approved in the application request to a different site must be approved by WVDH in writing prior to the relocation.

6. I agree to comply with all WVDH NIW Physician Monitoring and Reporting Requirements.

7. I understand and acknowledge that if I willfully fail to comply with the terms of this National Interest Waiver Affidavit and Agreement, the WVDH will notify the West Virginia Board of Medicine of my breach and will recommend my medical license be revoked or suspended.

Sworn to and subscribed before me this _____ day of _____ 20____.

_____
Notary Public

My commission expires:_____

Bureau for Public Health
Office of Community Health Systems and
Health Promotion WV State Office of Rural Health
350 Capitol Street, Room 515
Charleston, West Virginia 25301

NATIONAL INTEREST WAIVER APPLICATION

1. Physician Name _____ Specialty _____

2. Home Address _____
Street **City** **State** **Zip**

3. Home Telephone # _____ Home Email _____

4. Placing authority for the original J-1 Visa Waiver (if applicable): ____ Conrad State 30 ____ ARC

5. Date employment began _____

If you have more than one practice site, please list <u>all</u> practice locations.

6. Practice Name _____

Practice Address _____
Street **City** **Zip**

Practice Telephone _____ Practice Fax _____

Practice Name _____

Practice Address _____
Street **City** **Zip**

Practice Telephone _____ Practice Fax _____

7. Provide weekly work schedule.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

8. Do you accept Medicare patients? ____ Yes ____ No

9. Do you utilize a sliding/discounted fee schedule? ____ Yes ____ No

10. Do you accept Medicaid patients? ____ Yes ____ No

11. Is there any posted notice in your office regarding these charges? ____ Yes ____ No

I hereby acknowledge that all information and statements contained herein are true and do not misrepresent facts.

_____ _____
Signature **Date**

_____
Print Name

Submit the completed application and required documents to:

Bethlhem Amare, J-1 Coordinator
WV State Office of Rural Health
350 Capitol Street, Room 515
Charleston, West Virginia 25301-3716
Bethlhem.s.amare@wv.gov