



NATIONAL INTEREST WAIVER PROGRAM
Request For Attestation Letter
APPLICATION FORM

[Empty box for DOS Case Number]

(DOS Case Number)

PHYSICIAN INFORMATION

NAME (Last) (First) (Middle Initial)

CURRENT MAILING ADDRESS: (Street Address) (Apt Number) (City) (State) (Zip)

PHONE NUMBER: Home: ( ) Other: ( )

E-MAIL:

DISCIPLINE/SPECIALTY:

EMPLOYER INFORMATION (If different from the service site)

NAME OR ORGANIZATION:

MAILING ADDRESS: (Street Address) (Suite Number) (City) (State) (Zip)

NAME OF ADMINISTRATOR:

PHONE NUMBER: ( ) Fax: ( )

E-MAIL: ORGANIZATION TYPE:

**SERVICE SITE INFORMATION** (Submit one per site if multiple sites)

**NAME:** \_\_\_\_\_

**PHYSICAL ADDRESS:** \_\_\_\_\_

(Street Address)

(Suite Number)

\_\_\_\_\_  
(City)

(State)

(Zip)

**NAME OF ADMINISTRATOR:** \_\_\_\_\_

**PHONE NUMBER:** (     ) \_\_\_\_\_

**Fax:** (     ) \_\_\_\_\_

**E-MAIL:** \_\_\_\_\_

\_\_\_\_\_

**NAME OF FEDERALLY DESIGNATED AREAS IN WHICH THE SERVICE SITE IS LOCATED**

**HEALTH PROFESSIONAL SHORTAGE AREA (HPSA):** \_\_\_\_\_

**MEDICALLY UNDERSERVED AREA OR POPULATION (MUA/MUP):** \_\_\_\_\_



## STATEMENT OF UNDERSTANDING AND AGREEMENT OF PHYSICIAN

I, \_\_\_\_\_ having been duly sworn, state that I:

1. Have provided, as a J-1 provider, primary care (family or general practice, pediatrics, internal medicine, obstetrics and gynecology, or psychiatry), or specialty services on a full-time basis (at least 40 hours per week). As a J-1 provider, I have practiced for at least one year immediately preceding the date of the request for an ADHS NIW attestation letter at a qualifying service site located within a federally designated HPSA, MUA, MUP, or MHPSA, and will continue to do so while practicing under a national interest waiver based on an ADHS NIW attestation letter.
2. Will complete an aggregate of at least five years of medical service in an approved service site located in designated HPSA, MUA, MUP, or MHPSA to satisfy the national interest waiver obligation.
3. Will be an AHCCCS (Arizona Medicaid) and Medicare registered provider, accept other public health insurance options, accept all patients regardless of method of payment or ability to pay, provide services to those who have no health insurance coverage, will charge patients at the usual and prevailing rates in the area where I am practicing, and will have a sliding fee schedule (if applicable) based on ability to pay in place for all patients of the facility.
4. Will submit to the ADHS for review and approval a current sliding fee schedule and the procedure for its use at the site each year during my obligation under a national interest waiver. The sliding fee schedule will be based on the current [Federal Poverty Guidelines](#) as published in the Federal Register. Notice of the availability of this sliding fee schedule will be posted in a conspicuous location in the patient waiting area of the service site/facility or office where I am practicing.
5. Will submit for each calendar quarter a **notarized** encounter report, on an Encounter Report Form that can be accessed from the program website, prior to or by the 10<sup>th</sup> business day of the month after the end of each calendar quarter. The report will include the total number of encounters and the numbers of encounters using the sliding fee schedule.
6. Will notify the ADHS and complete a Transfer Request form before transferring to another location.

If I fail to comply with the terms of this Agreement, I understand that the ADHS will notify the U.S. Citizenship and Immigration Services of the Department of Homeland Security. Additionally, I understand that any and all other measures available to the ADHS will be taken in the event of my non-compliance.

\_\_\_\_\_  
Signature of foreign physician

\_\_\_\_\_  
Date

State of Arizona \_\_\_\_\_ )

County of \_\_\_\_\_ )

The foregoing instrument was acknowledged before me this \_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_,

By \_\_\_\_\_ .

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_



**CERTIFICATION OF SERVICE SITE**

I, \_\_\_\_\_ having been duly sworn, state that this service site:

1. Has the financial means available to support the physician, \_\_\_\_\_, seeking a national interest waiver.
2. Will employ the physician to provide full-time medical services (at least 40 hours per week) at a qualifying service site located in a federally designated HPSA, MUA, MUP, or MHPSA.
3. Will accept walk-in patients.
4. Is not an appointment-only practice.
5. Will accept all patients regardless of method of payment or ability to pay; will provide services to those who have no health insurance coverage; will accept AHCCCS, Medicare/Medicaid, and SCHIP assignments; will accept other public health insurance options; and will charge patients at the usual and prevailing rates in the area where the practice is located.
6. Will have a sliding fee schedule (if applicable) based on the current [Federal Poverty Guidelines](#) that will be used based on patient's ability to pay.
7. Will submit for ADHS review and approval a current sliding fee schedule and the procedure for its use at the site for each year of the physician's obligation under a national interest waiver based on an ADHS NIW attestation letter.  
**\*\*\*Attach a copy of the sliding fee schedule and the office procedure for its use.\*\*\***
8. Will submit a **notarized** quarterly encounter report, on an Encounter Report Form that can be accessed from the program website, prior to or by the 10<sup>th</sup> business day of the month after the end of each calendar quarter. The report will include the total number of encounters and the numbers of encounters using the sliding fee schedule.
9. Will notify the ADHS and complete a Transfer Request form before transferring the physician to another location

\_\_\_\_\_  
(Signature of Service Site's Executive Director/Administrator or Authorized Signer) (Date)

State of Arizona \_\_\_\_\_ )

County of \_\_\_\_\_ )

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_,

By \_\_\_\_\_ .

Notary Public

My Commission Expires: \_\_\_\_\_