Michigan Department of Health and Human Services

Request for a Letter of Support for a National Interest Waiver

(To be completed by the employer and printed on employer letterhead)

This form is an official request for a letter of support for a physician seeking a National Interest Waiver (NIW). The information below is provided to the Michigan Department of Health and Human Services regarding this physician, who is employed at our agency. The following information is provided to the State of Michigan:

1. Name of physician, including title (M.D. or D.O.):

   ____

2. Specialty/Specialties of the physician:

   ____

3. In what capacity (i.e., specialty) will this physician be practicing?

   ____

4. **Please list the name and address of the Clinic or Hospital Site where the NIW physician will provide service**. Up to five work sites may be listed below; if there are additional work sites, please include under the Additional Comments section on this form.

   1. ____

   2. ____

   3. ____

   4. ____

   5. ____

5. The health facility is a (check the type that best describes the site(s) identified above where the NIW physician will be employed):

   ____ Hospital
   ____ Hospital Clinic (hospital-administered clinic located outside of the hospital)
   ____ Private Practice Clinic
   ____ Federally Qualified Health Center
   ____ Local Health Department
   ____ State Clinic
   ____ Community Mental Health Clinic
   ____ State Psychiatric Hospital
   ____ State or Federal Correctional Facility
   ____ Critical Access Hospital (CAH) or CAH-administered clinic
   ____ Rural Health Clinic
   ____ Other, ____

6. Do all sites provide care to both Medicaid and Medicare patients?

   Yes____ No ____

7. Do all sites provide care to uninsured patients?

   Yes____ No____

8. Is it the intention of the employer to employ this NIW physician for the entire duration of the NIW obligation?

   Yes ____ No ____

9. Will the physician be employed full time (average of 40 or more hours per week)?

   Yes ____ No ____

10. Is this physician a current or former J-1 Visa Waiver recipient? Yes ____ No ____

    If yes, please list start date for J-1 Visa Waiver Obligation and sponsoring state:

    Obligation Start Date: ________________________________

    Sponsoring State: ___________________________________

    If no, does this physician have other applicable time working under the H-1B Visa?

    Yes ____ No ____

    Please list other applicable service locations and dates:

    ____

    ____

11. Additional comments and/or additional sites:

____

____

12. **Name, phone number, email, fax number and address of the physician, attorney or site administrator where the original letter will be mailed.** (The letter will first be faxed and then will be mailed).

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13. Name(s) and fax number(s) of the physician, attorney or site administrator where a copy of this letter should be faxed, if applicable.

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The signature below confirms that the above information is both accurate and true, and confirms that a letter of support for a NIW for the physician identified above is requested of the Michigan Department of Health and Human Services:

____

Signature **Date**

____

Printed Name of Site Administrator and Title

Employer must print this form on official letterhead, complete and sign the form and email to Sarah Kleis at KleisS1@michigan.gov.

Please allow up to 30 days for processing of this request.