



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



**National Interest Waiver (NIW) Program**

**Physician's Affidavit and Agreement**

- A. I, (print name) \_\_\_\_\_, being duly sworn, hereby request the New Hampshire Department of Health & Human Services (NH DHHS) 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
- B. I understand and acknowledge that NH DHHS reserves the right to deny support of a National Interest Waiver. NH DHHS 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.
- C. 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 United States Public Health Service (USPHS) as Health Professional Shortage Areas (HPSAs) Mental Health Professional Shortage Areas (MHPSAs), Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs), or Governor's Exceptional Medically Underserved Populations (E-MUPs).
- D. I understand and agree that the consideration for a "Letter of Attestation" and any resultant waiver, which eventually may or may not be granted, I shall render primary medical care, mental health, or dental health services to patients, including the indigent, for a minimum of forty (40) hours per week within the USPHS designated HPSAs, MHPSAs, MUAs, MUPs, or E-MUPs located in New Hampshire.
- E. 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:
- F. 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 Rural Health & Primary Care section immediately.
- G. In the event of a transfer to another employer or practice location(s), a formal transfer notification request must be submitted to the Rural Health & Primary Care section under the guidelines established by J-1 visas for such actions.
- H. I further agree that any employment agreement I enter to pursuant to paragraph 3 shall not contain any provision, which modifies or amends any of the terms of this NH Physician Affidavit and Agreement.
- I. I also agree to incorporate all terms of this NH Physician Affidavit and Agreement into any employment agreement I enter pursuant to paragraph 3.
- J. I understand that I must provide medical services to all patients regardless of their ability to pay. In addition, the health care provider & practice site must offer a sliding-fee-schedule based on current [Federal Poverty](#)

Guidelines, accept Medicaid, Medicare, and State Children’s Health Insurance Program assignment rates, and provide free care when medically necessary.

- K. The J-1 physician upon acceptance of a “Letter of Attestation” will need to sign a Memorandum of Agreement (MOA) with the NH DHHS before letter is sent to USCIS.
- L. I declare and certify, under penalty of the provisions of 18U.S.C. 1101, that I do not have pending nor am I submitting during the decision of this request, another request to any U.S. 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
- M. I understand and acknowledge that if I willfully fail to comply with the terms of this NH Physician Affidavit and Agreement, the NH DHHS will notify the USCIS and recommend deportation proceedings be instituted against me. Additionally, any and all measures available to the DPHS and/ or the NH Medical Board License will be taken in the event of non-compliance.
- N. I understand that I will need to provide semi annual reports to the Rural Health & Primary Care Section until my five-year commitment ends.

I, the above named physician, do provide (Practice/Specialty) \_\_\_\_\_ health care services and declare the penalties or perjury that the forgoing is true and correct.

Physician’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notary Republic Seal**