NATIONAL INTEREST WAIVER PHYSICIAN VERIFICATION OF EMPLOYMENT FORM

SECTION I

PHYSICIAN NAME:_____
Please Print

EMPLOYMENT START DATE AT SPONSORING MEDICAL FACILITY: _____

INS J-1 Visa Waiver Approval Date: _____ H-1B Visa Approval Date: _____

PHYSICIAN'S HOME ADDRESS:

_____
Street City State Zip Code:

Email: _____

Home Phone: _____ CELL Phone: _____

SECTION II
PRACTICE SITE INFORMATION

Name Site 1:	Name Site 2:
Street Address:	Street Address:
City, State, ZIP	City, State, ZIP
Site Phone #:	Site Phone #:

SECTION III

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE OR SPECIALITY CARE (IF APPROVED AS SPECIALIST) AT THE ABOVE STATED SITE(S) A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Physician's Signature **Date**

SECTION IV
THIS SECTION TO BE COMPLETED AND SIGNED BY SPONSORING MEDICAL FACILITY:

I HEREBY CERTIFY THAT DOCTOR_____

(Please Check Below As Applicable)

(___) IS WORKING AT SITE(S) LISTED IN SECTION II AND IS IN YEAR _____ OF THE FIVE YEAR SERVICE OBLIGATION

(___) HAS COMPLETED SERVICE OBLIGATION AND *STILL* AT SITE(S) LISTED IN SECTION II

(___) HAS COMPLETED SERVICE OBLIGATION AND NO LONGER AT SITE(S) LISTED IN SECTION II

(___) DID NOT COMPLETE SERVICE OBLIGATION

(___) TRANSFERRED

(___) WILL START ON _____ AT SITE(S) LISTED IN SECTION II

_____
Printed Name of Sponsoring Medical Facility Representative

_____ _____
Signature of Sponsoring Medical Facility Representative **Date**

(THIS FORM MUST BE NOTARIZED)

RETURN THIS FORM BY MAIL TO:
Mississippi State Department of Health
ATTN: Director, Office of Rural Health & Primary Care
570 East Woodrow Wilson - P. O. Box 1700
Jackson, Mississippi 39215-1700