

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

MASSACHUSETTS NATIONAL INTEREST WAIVER (NIW) REQUIREMENTS

The Massachusetts NIW program is administered by the Health Care Workforce Center (HCWC) for the Department of Public Health (DPH). Please contact Nicole Watson at the HCWC with any NIW communication or questions:

Nicole Watson
DPH-250 Washington Street, 5th Floor
Boston, MA. 02108-4619
nicole.watson@state.ma.us
617- 624-6051

Support letters are sent to the requestor representative. The HCWC does not play a role in this NIW process outside of producing a support letter. Please allow approximately three weeks for a response from the HCWC.

INSTRUCTIONS

Physicians with a waiver supported by Massachusetts provide both a completed and current Application Information Sheet (see below) and a request letter from the health care facility where the physician is or will be practicing.

Non-Massachusetts Supported Physicians provide a:

- Completed Application Information Sheet (see below)
- Request letter from the health care facility where the physician is or will be providing services.
- Facility description.
- Copy of the signed employment contract as evidence of a valid position.
- Copy of the physician's current resume and Massachusetts license to practice.

If the physician obtained and met a visa waiver obligation in another state or territory, also provide a letter from the appropriate office in that state or territory confirming that the three (3) year waiver commitment has been met. This letter must include, physician's name, specialty, practice site name, practice site type, practice site address, start and end date of commitment.

**Health Care Workforce Center-Visa Waiver Program
Massachusetts Department of Public Health (MDPH)
250 Washington St. Boston, MA 02108-4619
Conrad-30/J-1 Visa Program or National Interest Waiver**

Physician Last Name: Male Female

Physician First Name: MI:

Date of Birth: Dept of State Case #:

Country of Birth:

Practice/Specialty:

Purpose of request for letter from MDPH: (check one) Conrad-30 Program National Interest Waiver

Employer Name:

Employer Address:

Employer Contact Name: Phone:

Email of Contact:

Practice Site 1 Name: Medicaid Billing Number:

Practice Site 1 Address:

County: Census Tract: Hours to be spent at this site:

HPSA #: MUA or MUP # (if applicable):

Practice Site 2 Name: Medicaid Billing Number:

Practice Site 2 Address:

County: Census Tract: Hours to be spent at this site:

HPSA #: MUA or MUP # (if applicable):

Lawyer Name (write N/A if none): Email:

Law Firm Name:

Law Firm Address:

Phone:

Fax: