Illinois National Interest Waiver Letter Request Form

Please provide the following information.

1. Physician's full name: _____

2. SRC/WAC/EAC#: _____

3. Practice name: _____

4. Physician's gender: _____

5. Practice address: _____

_____ IL _____

City St Zip

6. Practice county(ies): _____

7. Physician's specialty: _____

8. Physician sponsor's name and address: _____

_____

_____ IL _____

City State Zip

9. Begin and end dates for service to the area(s): _____

10. Attach a copy of the H1B visa waiver(s) that identify the site address and sponsor.

11. Attach a copy of the physician's Illinois medical license.

12. Attach an affirmation letter on letterhead stationery from the employer stating that the:

    a. Physician has provided services as a primary care, psychiatric or specialty physician;

    b. Dates that the clinical services are/were provided;

    c. Physician worked full-time (40 hours per week) at the clinical practice;

    d. Site name and specific street address where services are/were provided , which is located in a HPSA, MUA or MUP;

    e. Practice is in the public interest in Illinois, including information that the physician served underinsured or uninsured patients as evidenced by acceptance of Medicaid, Medicare and use of a sliding/discount fee scale for those without insurance in the designated underserved area.

13. Provide a name, address, phone and fax number or email address where you would like the letter sent.

_____

Name

_____

Address

_____

City St Zip

_____

Phone and Fax Number Email address:

Return this form to the Illinois Department of Public Health by fax (217-782-2547) or e-mail to dph.crh@illinois.gov and a letter will be prepared based on the above information.

Revised 3/30/2016