# Request for a CDPH Letter to include with a National Interest Waiver Application

Physician's Name:_________________________________________ Date of Birth:______________
DPH License number: ____________________ Month/ Day/Year
USCIS(formerly INS) Case Number: __________________ .

Practice Location*
Address:_______________________________________________________________

Is this a federally designated shortage area? ______Yes _______No

Type of Designation: MUA/P_____
HPSA_____ id#: ____________________

Are you currently on a J-1 VISA? ______Yes _______No

*If the above address is less than a full-time (i.e. 40 hours per week) practice commitment, please provide the same information for other practice locations on the reverse of this page, and show hours at each site.

*For mailing purposes, please provide*:
Physician's Address:
_____________________________________________________________________

*If applicable*, list here the requested additional address/person or organization to send an original letter to:
_____________________________________________________________________
_____________________________________________________________________

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*The following information is for internal DPH use only for affirmative action and health access planning purposes. This information is not a requirement to receive a state attestation letter.*

Specialty (if any):_______________________________________________________________
Board certification(s), if any:_______________________________________________________
Language(s) spoken other than English, if any: ________________________________________
Country of Origin:____________________ Any Other Country where you have resided for more than three months since 1990:____________________________________________________
_____________________________________________________________________________

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The information supplied is true and complete. I intend to serve the needy population while practicing at the shortage location listed above if my National Interest Waiver application is approved.
Signed: ___________________________________________________ Date: ___________________
Physician Requesting National Interest Waiver letter

## Completed Request Form should be mailed to:

Public Health Services and Equity
National Interest Waiver Program
410 Capitol Ave. MS#13 PHSE, PO Box 340308
Hartford, CT 06134-0308
DPH-PCO@ct.gov