Delta Doctors Program

National Interest Waiver Review Checklist

Process Start Date:	
Date Received:	
Reviewer Date:	
Copy of FCC's Letter File:	☐
Copy of Shipping Receipt:	☐
Emailed Attorney Letter:	☐
Tracking Number:	

Physician's Name: _____

DOS Case Number: _____

DOB: _____

Current Address: _____

_____

Country of Origin: _____

Specialty: _____

Worksite Name & Address: _____

_____

_____

MUA Number: _____

HPSA Number: _____

County/Parish: _____

**Provide additional worksites with MUA/HPSA numbers on a separate page.*

Attorney: _____

Firm Name: _____

Attorney Address: _____

_____

Attorney Phone Number: _____

Attorney Fax Number: _____

Attorney Email: _____

Employer's Name: _____

Employer Contact: _____

Employer's Address: _____

_____

Employer Phone Number: _____

Employer Fax Number: _____

Employer Email: _____

☐ 1 Letter of Opinion from Legal Representatives

☐ 2 Form G-28

☐ 3 Physician Statement

☐ 4 Copy of Executed Contract

- ☐ Signed/dated by Physician/Employer
- ☐ 5 Year (NIW)
- ☐ 40 Hours per week or 160 hours per month of direct patient care
- ☐ Service to Medicaid/Meidcare/Indigent Patients
- ☐ Base Salary: _____
- ☐ Name of each worksite and address

☐ 5 Copies of Diplomas, licenses or applications for licenses

- ☐ State medical license or applicaton for license
- ☐ USMLE Scores

☐ 6 Complete passport (Verify all pages)

- ☐ I-129 Immigration Petition Approval Notice
- ☐ H-1B Approval Notices
- ☐ Copy of I-94

Summary of Reviewer's Findings: