



NATIONAL INTEREST WAIVER REQUEST FORM

PHYSICIAN:

Full Name: _____

Home Address: _____
Street City State Zip

Date of Birth: _____ Origin of Birth: _____

Social Security # _____ Kansas Medical License # _____

Phone: _____ Email Address: _____

Start work date: _____ Practice Specialty _____

Please provide a written statement that:

- Describes the need for your services in the HPSA/MUA
- Describes how approval of the waiver is in the national interest

SPONSORING EMPLOYER:

Name of Employment Site: _____

Complete Address: _____
Street City State Zip

Phone: _____ County: _____

HPSA ID: _____

The sponsoring employer must submit a letter that includes:

- Full name of physician
- Site name and address
- Verification that the physician is in good standing
- Description of services physician will provide
- Documentation of need for the physician's services
- Affirmation that the physician will practice full-time (40 hours per week) in a HPSA or MUA
- Description of the effects of denial of the National Interest Waiver to the facility and to the HPSA/MUA

Please submit a copy of the current employment contract along with the above information to:

Barbara Huske, Director
State Primary Care Office
KDHE Bureau of Community Health Systems
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365
Phone: (785) 296-2742
Email: bhuske@kdheks.gov