

**Delta Regional Authority Delta Doctors Program  
Internal Application Review Sheet Page 1**

Process Start Date:	_____	Physician's Name:	_____
Date Received:	_____	DOS Case No.:	_____
Date Notified State Coordinator:	_____	DOB:	_____
Deadline for State Coordinator:	_____	Country of Origin:	_____
Check Copied/ original to DFA:	_____	Specialty:	_____
Reviewer/ Date:	_____	Current Address:	_____
DRA Database No:	_____		_____
Date Sent to DOS:	_____	Phone No.:	_____
Tracking Number:	_____	E-mail Address:	_____
Copy of FCC's Letter to File:	_____	MUA No.:	_____
Copy of Shipping Receipt Made:	_____	HPSA No.:	_____
Faxed Attorney Copy of Letter:	_____	Term:	_____
DRA Alternate Notification:	_____		
Conrad Coord. Notification:	_____	Work Site:	_____
Copy of Conrad Comments:	_____		_____
Congressional Staff Notification:	_____		_____
		County / Parish:	_____
Attorney:	_____	Employer's Name:	_____
Firm Name:	_____	Employer Contact:	_____
Attorney Address:	_____	Employer's Address:	_____
			_____
Attorney Phone No:	_____	Employer Phone No:	_____
Attorney Fax No:	_____	Employer Fax No:	_____
Attorney E-mail:	_____	Employer E-mail:	_____

## Internal Application Review Sheet Page 2

- \_\_\_\_\_ 1 Letter of Opinion from Legal Representation  
\_\_\_\_\_ requesting NIW?
- \_\_\_\_\_ 2 G-28 with application fee of \$ 3,000.00
- \_\_\_\_\_ 3 Cover Letter From Employer / Facility  
\_\_\_\_\_ NIW support  
\_\_\_\_\_ MUA No. \_\_\_\_\_  
\_\_\_\_\_ HPSA No. \_\_\_\_\_  
\_\_\_\_\_ FIPS No. \_\_\_\_\_  
\_\_\_\_\_ Physician Information \_\_\_\_\_  
\_\_\_\_\_ Medicare/Medicaid/Indigent-3yr. Data \_\_\_\_\_  
\_\_\_\_\_ Check Patient to Physician Ratio \_\_\_\_\_
- \_\_\_\_\_ 4 DRA J-1 Policy Document  
\_\_\_\_\_ Signed/dated by Physician/Employer
- \_\_\_\_\_ 5 DRA Affidavit and Agreement  
\_\_\_\_\_ Signed/dated/notarized by Physician  
\_\_\_\_\_ Verify all pages are included.
- \_\_\_\_\_ 6 DOS Data Sheet & DOS Case Number Sheet  
\_\_\_\_\_ 2 copies  
\_\_\_\_\_ Verify DOS No. on website
- \_\_\_\_\_ 7 CV with SSN
- \_\_\_\_\_ 8 DOS Exchange Visitor Attestation Form  
\_\_\_\_\_ Signed/dated/notarized by Physician
- \_\_\_\_\_ 9 Copy of Executed Contract  
\_\_\_\_\_ Signed/dated by Physician/Employer  
\_\_\_\_\_ 3 year service \_\_\_\_\_ 5 year (NIW)  
\_\_\_\_\_ No non-compete clause  
\_\_\_\_\_ 40 hours per week of Primary Care  
\_\_\_\_\_ Service to Medicaid/Medicare/Indigent Patients  
\_\_\_\_\_ Base Salary is: \_\_\_\_\_  
\_\_\_\_\_ Name of facility and address  
\_\_\_\_\_ DRA Liquidated Damages Clause Included
- \_\_\_\_\_ 10 Proof of Prevailing Wage Data  
Level I \_\_\_\_\_ Level II \_\_\_\_\_

### Internal Application Review Sheet Page 3

- \_\_\_\_\_ 11 Recruiting Documentation
- \_\_\_\_\_ Recruitment Overview Sheet
  - \_\_\_\_\_ National level
  - \_\_\_\_\_ State level
  - \_\_\_\_\_ State Medical Schools
  - \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_ 12 Proof of MUA/HPSA Status
- \_\_\_\_\_ Verify Status on Website
- \_\_\_\_\_ 13 Letter of Community Support
- \_\_\_\_\_ Addressed to FCC
  - \_\_\_\_\_ (2) local physicians
  - \_\_\_\_\_ Others: \_\_\_\_\_
- \_\_\_\_\_ 14 Letters of Recommendation
- \_\_\_\_\_ Addressed to FCC
- \_\_\_\_\_ 15 Copies of Diplomas, licenses, board certifications, etc.
- \_\_\_\_\_ State medical license or application for license
- \_\_\_\_\_ 16 Proof of facility's existence
- \_\_\_\_\_ 17 Copy of Facility's Posted Public Notice of Sliding Fee Pymt.
- \_\_\_\_\_ 18 List of primary care doctors or specialists in county/parish
- \_\_\_\_\_ 19 Complete passport (Verify all pages)
- \_\_\_\_\_ 20 IAP-66/DS-2019
- \_\_\_\_\_ Verify from entry to present
- \_\_\_\_\_ 21 Copy of 1-94
- \_\_\_\_\_ Front and back
- \_\_\_\_\_ 22 Physician Statement \_\_\_\_\_ NIW statement if applicable

