University of Connecticut
Health Center

**DEPARTMENT OF HUMAN RESOURCES**
Telephone: (860) 679-4430 Fax: (860) 679-4115

**Request for Issuance of Form DS-2019 - Exchange Visitor Status (J-1)**

**IMPORTANT: EXCHANGE VISITORS ARE PROHIBITED FROM RE-ENTERING THE U.S. FOR TWELVE (12) MONTHS FOLLOWING PHYSICAL PRESENCE IN THE U.S. IN J-1 or J-2 STATUS. N/A for SHORT TERM SCHOLAR**

**(Due to National Security issues, this information willneed to be accurate and typed)**

Name of Foreign Visitor_____ ( )M ( )F
(as it appears in the passport) Family First Middle
Date of Birth_____Place of Birth_____
Month/Day/Year City Country
Country of Legal Permanent Residence_____Citizenship_____

Foreign Address in home country_____
**(P.O. Box cannot be accepted)**

Profession and Position in Home Country_____

Name of Home Institution/Business_____

Is person presently in the U.S.?____ Under what status and where?_____(Attach copies)

**Category of Visitor's Proposed Activity at the Health Center**: ( ) Student [No Self Funding]
( ) Short Term Scholar [Maximum Stay 6 Months] ( ) Research Scholar ( ) Professor

Visitor's Project at UCHC_____
UCHC Payroll Title_____ Regular Payroll_____ Special Payroll_____

Beginning Date:_____ Ending Date:_____
Month/Day/Year Month/Day/Year

**SOURCE(S) AND AMOUNT(s) OF FINANCIAL SUPPORT FOR VISITOR'S STAY**

The United States government requires verification of adequate financial support and health insurance for foreign visitors and their accompanying dependents. **Signers of this form are responsible for this verification. See enclosed form for minimum amounts allowed.**

| | Source of Financial Support | Amount in U.S. $ for Entire Length of Stay |
|---|---|---|
| ( ) | University of Connecticut | $_____ |
| ( ) | U.S. Government Agency(ies)List: 1 | $_____ |
| ( ) | The Exchange Visitor's Government | $_____ |
| ( ) | Binational Commission of Visitor's Country | $_____ |
| ( ) | All Other Organizations Providing Support<br>Please specify:_____ | $_____ |
| ( ) | Personal Funds | $_____ |

Family Members: Will family accompanying foreign national? OR ( )Yes ( )No
Will family enter the U.S. at a later date? ( )Yes ( )No
Use back of form for information on accompanying family members.

Alien ( ) **will** ( ) **will not** be provided medical insurance by this department. We will immediately notify the International Office if the alien and/or dependents fail to maintain mandatory medical insurance regulations during sponsorship period. We understand the alien's program will be terminated if alien willfully fails to maintain said coverage for their and dependents.

Faculty Sponsor_____
Name (Please print or type) Signature Date
Department_____Extension_____MC_____

Contact Person_____Extension_____

Department Head's Signature of Approval_____Date_____

Return this form with copy of acceptance/offer letter and, if appropriate, No Patient Contact or Dean's Statement (N/A for Dental).
**Minimum education** for Researchers is a **Masters degree** or **Bachelors degree w/extensive experience in the relevant field**

NAME OF SPOUSE: _____ ( ) M, ( )F
(as it appears in the passport) Last name First name

Date of Birth: _____ Citizenship: _____

Place of Birth: _____

Country of legal Permanent Residence_____

Foreign Address: _____
**(P.O. Box cannot be accepted)**

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NAME OF CHILD: _____ ( ) M, ( )F
(as it appears in the passport) Last name First name

Date of Birth: _____ Citizenship: _____

Place of Birth: _____

Country of legal Permanent Residence_____

Foreign Address: _____
**(P.O. Box cannot be accepted)**

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NAME OF CHILD: _____ ( ) M, ( )F
(as it appears in the passport) Last name First name

Date of Birth: _____ Citizenship: _____

Place of Birth: _____

Country of legal Permanent Residence_____

Foreign Address: _____
**(P.O. Box cannot be accepted)**

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