



**APPLICATION FOR EXTENSION OF FORM DS-2019
Certificate of Eligibility for J-1 Exchange Visitor
Please circle category: Professor/Researcher/Short-Term Scholar/Specialist**

Extension request should be submitted no less than two months before the expiration date.

Submit this extension request form to Dr. Ana M. Sippin, Director, Office of International Student & Scholar Services, to prepare form DS-2019 for the below-named foreign national, who is at FIU as a professor, researcher, short-term scholar or specialist.

Name of Faculty Member Making Request Title

Department/Campus Address/Extension Contact Person Extension

EXCHANGE VISITOR INFORMATION: PLEASE TYPE OR PRINT CLEARLY

NAME: _____ MALE _____
FAMILY NAME GIVEN

ADDRESS IN HOME COUNTRY: _____ FEMALE _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____
(Mo/day/yr) (City) (Country)

CITIZEN OF: _____ PERMANENT RESIDENT OF: _____

EMAIL ADDRESS: _____ POSITION IN HOME COUNTRY: _____

CURRENT U.S. ADDRESS: _____

ANTICIPATED DATES OF EXTENSION: _____ TO _____
(MO/DAY/YR) (MO/DAY/YR)

DOES THIS EXCHANGE VISITOR WISH TO PURSUE A DEGREE AT FIU? _____ SUBJECT FIELD OF RESEARCH/TEACHING: _____

PLEASE PROVIDE A SPECIFIC DESCRIPTION OF THIS EXCHANGE VISITOR'S STUDY, RESEARCH, AND PROFESSIONAL ACTIVITIES AT FIU:

EXCHANGE VISITOR'S DEPENDENTS: THIS EXCHANGE VISITOR WILL

_____ CONTINUED TO BE ACCOMPANIED BY _____ DEPENDENTS DURING THE EXTENSION.

_____ BE JOINED BY _____ DEPENDENTS ON _____.

_____ NOT BE ACCOMPANIED BY DEPENDENTS DURING HIS/HER FIU PROGRAM.

IF APPLICABLE, PLEASE ATTACH A SEPARATE SHEET LISTING THE FOLLOWING ABOUT EACH DEPENDENT WHO WILL ACCOMPANY OR JOIN THE EXCHANGE VISITOR: NAME, RELATIONSHIP TO THE EXCHANGE VISITOR, DATE OF BIRTH, COUNTRY OF BIRTH, AND COUNTRY OF CITIZENSHIP, ADDRESS IN HOME COUNTRY AND EMAIL ADDRESS FOR EACH DEPENDENT. NOTE: DEPENDENTS MUST BE ENROLLED IN THE MEDICAL INSURANCE PLAN AVAILABLE FOR FIU STUDENTS AND SCHOLARS.

PLEASE INDICATE THE DOLLAR AMOUNT OF SUPPORT WHICH WILL BE PROVIDED FOR THE EXCHANGE VISITOR BY FIU:

\$ _____ DEPARTMENT _____

PLEASE INDICATE BELOW THE SPECIFIC SOURCE(S) AND AMOUNT(S) OF THE EXCHANGE VISITOR'S FUNDING FROM NON-FIU SOURCES:

_____ U.S. GOVERNMENT AGENCY _____
(AGENCY) (AMOUNT)

_____ EXCHANGE VISITOR'S GOVERNMENT _____
(GOVERNMENT) (AMOUNT)

_____ BI-NATIONAL COMMISSION OF EXCHANGE VISITOR'S COUNTRY _____
(COMMISSION) (AMOUNT)

_____ ALL OTHER ORGANIZATIONS _____
(NAME/S) (AMOUNT)

_____ PERSONAL FUNDS/PRIVATE SPONSOR _____
(NAME/S) (AMOUNT)

EXCHANGE VISITOR MEDICAL INSURANCE: PLEASE CHECK ONE:

_____ THIS EXCHANGE VISITOR AND DEPENDENTS WILL PURCHASE THE FIU APPROVED MEDICAL INSURANCE POLICY PRIOR TO ISSUANCE OF THE DS-2019 FORM. ENROLLMENT FORM AND PAYMENT ATTACHED.

_____ THIS EXCHANGE VISITOR AND DEPENDENTS WILL BE COVERED BY THE MEDICAL INSURANCE PLAN OFFERED AS PART OF THE STANDARD PACKAGE AVAILABLE TO EXCHANGE VISITORS WHO ARE UNIVERSITY EMPLOYEES AND WILL PURCHASE A SEPARATE POLICY PROVIDING EMERGENCY MEDICAL EVACUATION AND REPATRIATION. DOCUMENTATION INDICATING EFFECTIVE DATE OF COVERAGE IS REQUIRED TO ISSUING THE DS-2019 FORM. IF THE EXCHANGE COMMENCES PRIOR TO THE EFFECTIVE DATE OF COVERAGE, THE EXCHANGE VISITOR AND DEPENDENTS WILL PURCHASE THE FIU APPROVED POLICY THAT PERIOD OF TIME.

CERTIFICATION OF FACULTY SPONSOR: PLEASE READ AND SIGN.

I CERTIFY THAT I AM EXTENDING AN INVITATION TO THE EXCHANGE VISITOR NAMED HEREIN FOR FIU TO PURSUE THE ACTIVITIES DELINEATED ABOVE. FUNDING WILL BE PROVIDED AS INDICATED FOR THE PERIOD CERTIFIED ABOVE. I UNDERSTAND THAT ALL EXCHANGE VISITORS ARE REQUIRED BY FEDERAL REGULATION AND FIU TO CARRY ADEQUATE MEDICAL INSURANCE, AND I WILL ENSURE THAT THIS EXCHANGE VISITOR CARRIES MEDICAL INSURANCE AS DESCRIBED ABOVE. I UNDERSTAND AND WILL EXPLAIN TO THIS EXCHANGE VISITOR THAT EXCHANGE VISITOR SCHOLARS/RESEARCHERS ARE NOT PERMITTED TO CHANGE TO THE STUDENT CATEGORY AFTER THEIR ENTRY INTO THE UNITED STATES.

SIGNATURE OF FACULTY SPONSOR

DATE

CERTIFICATION OF DEPARTMENT HEAD/ACADEMIC DEAN: PLEASE REVIEW THIS DOCUMENT IN FULL AND INDICATE SUPPORT AND APPROVAL BY SIGNING BELOW.

DEPARTMENT HEAD SIGNATURE

NAME (PRINTED)

DATE

ACADEMIC DEAN SIGNATURE

NAME (PRINTED)

DATE

APPROVAL OF DIRECTOR, OFFICE OF INTERNATIONAL STUDENT & SCHOLAR SERVICES: SIGNATURE BELOW INDICATES APPROVAL TO PREPARE AND ISSUE FORM DS-2019 FOR THE ABOVE-NAMED EXCHANGE VISITOR.

Dr. Ana M. Sippin, Director
International Student & Scholar Services or designee

DATE