

APPLICATION FOR INITIAL FORM DS-2019
Certificate of Eligibility for J-1 Exchange Visitor
Non-Degree Student

To complete this form, please refer to the attached instructions. Submit this request to *Office of International Student & Scholar Services*, Attention; Dr. Alejandra Parra and Ted Randall.

Name of Faculty Member Making Request _____ Title _____

Department/Campus Address _____ Contact Person _____ Extension _____

EXCHANGE VISITOR INFORMATION: PLEASE TYPE OR PRINT CLEARLY

NAME: _____ MALE _____
FAMILY NAME GIVEN FEMALE _____

ADDRESS IN HOME COUNTRY: _____

DATE OF BIRTH: _____ (mo/day/yr) PLACE OF BIRTH: _____ (city) _____ (country)

CITIZEN OF: _____ PERMANENT RESIDENT OF: _____

POSITION IN HOME COUNTRY: Student Student's EMAIL: _____

HAS THIS PROSPECTIVE EXCHANGE VISITOR BEEN PREVIOUSLY IN THE UNITED STATES AS AN EXCHANGE VISITOR IN J-1 STATUS? IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION AND ATTACH COPIES OF ALL DS-2019 FORMS ISSUED:

DATES LOCATION CATEGORY

U.S. ADDRESS IS/WILL BE: Florida International University, 11200 SW 8th Street, Modesto A. Maidique Campus, Miami, FL 33199

ANTICIPATED DATES OF FIU PROGRAM: _____ (mo/day/yr) TO _____ (mo/day/yr)

IS THE EXCHANGE VISITOR CURRENTLY IN A DEGREE PROGRAM AT ANY UNIVERSITY? yes

IF YES, PLEASE INDICATE DEGREE SOUGHT, MAJOR FIELD, INSTITUTION AND LOCATION:

DOES THIS EXCHANGE VISITOR WISH TO PURSUE A DEGREE AT FIU? no

SUBJECT FIELD OF STUDY: N/A

PLEASE PROVIDE A SPECIFIC DESCRIPTION OF THIS EXCHANGE VISITOR'S STUDY, RESEARCH, AND PROFESSIONAL ACTIVITIES AT FIU AND THE LEVEL (UNDERGRADUATE OR GRADUATE):

EXCHANGE VISITOR'S DEPENDENTS: THIS EXCHANGE VISITOR WILL

_____ **BE ACCOMPANIED BY** _____ **DEPENDENTS UPON ARRIVAL TO FIU.**
_____ **COME ALONE AT FIRST AND BE JOINED BY** _____ **DEPENDENTS LATER.**

_____ **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 AND ADDRESS IN HOME COUNTRY. NOTE: DEPENDENTS MUST BE ENROLLED IN THE MEDICAL INSURANCE PLAN AVAILABLE FOR FIU STUDENTS AND SCHOLARS.

DOCUMENTATION OF FUNDING: ALL AMOUNTS AND SOURCES MUST BE INDICATED BELOW AND DOCUMENTED IN SUPPORTING MATERIALS. PLEASE REFER TO THE INSUTRCTIONS FOR COMPLETING DS-2019 REQUEST FORM FOR COMPLETE INFORMATION ABOUT REQUIRED DOCUMENTATION OF SUPPORT.

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 BENEFITS 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 PRIOR TO ISSUING THE DS-2019 FORM. IF THE EXCHANGE VISITOR'S PROGRAM COMMENCES PRIOR TO THE EFFECTIVE DATE OF COVERAGE, THE EXCHANGE VISITOR AND DEPENDENTS WILL PURCHASE THE FIU APPROVED POLICY FOR THAT PERIOD OF TIME.**

CERTIFICATION OF FACULTY SPONSOR: PLEASE READ AND SIGN.

I CERTIFY THAT I AM INVITING THE PROSPECTIVE 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 CATERGORY 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. Alejandra Parra, Director _____ **DATE**
International Student & Scholar Services or
designee