

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
 WASHINGTON, D.C.
 APPLICATION FOR WAIVER OF THE TWO-YEAR FOREIGN
 RESIDENCE REQUIREMENT OF THE EXCHANGE VISITOR PROGRAM
 Supplement A – Research Supplement B – Clinical Care**

SECTION 1. APPLYING INSTITUTION AND PROGRAM

1. NAME OF INSTITUTION	2. TELEPHONE, AREA & NUMBER
3. COMPLETE ADDRESS	
4. NAME AND POST OF RESPONSIBLE ADMINISTRATIVE OFFICER WHO CERTIFIES THIS APPLICATION AND THE DATA IT CONTAINS	
5. PROGRAM (Department or Division) IN WHICH EXCHANGE VISITOR IS ENGAGED	
6. PRINCIPAL PROGRAM OFFICER, RANK AND POSITION (Supplement A)	MEDICAL DIRECTOR (Supplement B)
7. SOURCE OF PROGRAM FUNDS (Supplement A ONLY) - If supported by HHS or other public funds, identify grants by source, title, number and amount and terminal dates.	

SECTION 2. RELATION OF EXCHANGE VISITOR TO INSTITUTION AND PROGRAM

8. PRESENT POSITION CLASSIFICATION AND SALARY

(1) HOW LONG HAS THIS PERSON BEEN EMPLOYED IN THE INSTITUTION? (Supplement A ONLY)	(2) IN THE PROGRAM?
(3) WHAT EFFORTS HAVE BEEN MADE TO REPLACE THIS INDIVIDUAL?	(4) AT WHAT SALARY?
	(5) WITH WHAT RESULTS?

SECTION 3. EXCHANGE VISITOR FOR WHOM WAIVER IS REQUESTED

9. NAME (Surname) (Given names) (Maiden name, if married female)	
10. RESIDENTIAL ADDRESS (No., Street, City, State or Province, Country)	
11. CURRENT ADDRESS OF SPOUSE, IF DIFFERENT	
12. OCCUPATION TITLE	
13. DATE OF BIRTH (Month, Day, Year)	14. BIRTHPLACE (City, State, Country)
15. SEX: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	16. MARITAL STATUS: MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/>
17. CITIZENSHIP	18. COUNTRY OF LAST RESIDENCE BEFORE ENTERING U.S.A.
20. ALIEN REGISTRATION NO.	19. IF NO LONGER IN U.S.A., STATE LAST PLACE OF U.S. RESIDENCE (City & State)
21. LOCAL IMMIGRATION OFFICE WHERE REGISTERED	22. DATE OF ENTRY INTO U.S.A. AS EXCHANGE VISITOR
23. EXPIRATION DATE OF CURRENT PERMIT (I-94)	
24. WHAT FUNDS WERE USED TO FINANCE THE EXCHANGE VISIT? U.S. GOV'T <input type="checkbox"/> U.N. OR AFFILIATE <input type="checkbox"/> PRIVATE AGENCY <input type="checkbox"/> VISITORS GOV'T <input type="checkbox"/> OTHER <input type="checkbox"/> (If government agency, please identify)	

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26. OTHER APPLICATIONS, IF ANY, FOR FOREIGN RESIDENCE WAIVER FOR THIS VISITOR	
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27. FAMILY (If married, list dependents)

NAME	BIRTHDATE	BIRTHPLACE	VISA TYPE
(Spouse)			
(Children)			

28. EDUCATION (college, postgraduate, other)

NAME AND LOCATION OF INSTITUTION EXCHANGE VISITOR PROGRAM # <i>any</i>	DATES ATTENDED		YEARS COMPLETED	DEGREE (S) RECEIVED	<i>(if</i>
	FROM	TO			

29. EXPERIENCE

EXCHANGE NAME AND LOCATION OF ORGANIZATION VISITOR PROGRAM # <i>any</i>	PERIOD OF SERVICE		NATURE OF ASSIGNMENT <i>(Start with current assignment and work back)</i>	<i>(if</i>
	FROM	TO		

SECTION 4. CERTIFICATION OF ACCURACY OF INFORMATION AND APPLICATION

Signature of Principal Program Officer (**Supplement A**)

DATE

Signature of Medical Director (**Supplement B**)

DATE

Signature of Responsible Administrative Officer
FORM HHS 426(REV. 03/03)

DATE