

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C.**  
APPLICATION FOR WAIVER OF THE TWO-YEAR FOREIGN  
RESIDENCE REQUIREMENT OF THE EXCHANGE VISITOR PROGRAM

O.M.B. NO. 0990-0001

**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 ( <i>Department or Division</i> ) IN WHICH EXCHANGE VISITOR IS ENGAGED	
6. PRINCIPAL PROGRAM OFFICER, RANK AND POSITION ( <i>Supplement A</i> )	MEDICAL DIRECTOR ( <i>Supplement B</i> )
7. SOURCE OF PROGRAM FUNDS ( <b>Supplement A ONLY</b> ) - <i>If supported by HHS or other public funds, identify grants by source, title, number and amount and terminal dates.</i>	

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

26. OTHER APPLICATIONS, IF ANY, FOR FOREIGN RESIDENCE WAIVER FOR THIS VISITOR		
DATE OF APPLICATION	TO FEDERAL AGENCY	BY INSTITUTION

27. FAMILY (If married, list dependents)			
NAME	BIRTHDATE	BIRTHPLACE	VISA TYPE
(Spouse)			
(Children)			

28. EDUCATION (college, postgraduate, other)	DATES ATTENDED		YEARS COMPLETED	DEGREE (S) RECEIVED	EXCHANGE VISITOR PROGRAM # (if any)
	FROM	TO			
NAME AND LOCATION OF INSTITUTION					

29. EXPERIENCE	PERIOD OF SERVICE		NATURE OF ASSIGNMENT (Start with current assignment and work back)	EXCHANGE VISITOR PROGRAM # (if any)
	FROM	TO		
NAME AND LOCATION OF ORGANIZATION				

**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

\_\_\_\_\_  
DATE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0900-0001. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: DHHS/OS/OIRM/PRA, 200 Independence Avenue, S.W., Washington, D.C. 20201, Room 531-H-95, Attn: PRA Reports Clearance Officer.