O.M.B. NO. 0990-0001

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 ☐ FEMALE ☐

16. MARITAL STATUS: MARRIED ☐ SINGLE ☐

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.

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 ☐ U.N. OR AFFILIATE ☐ PRIVATE AGENCY ☐ VISITORS GOV'T ☐ OTHER ☐

(If government agency, please identify)

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)*

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

29. EXPERIENCE

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

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*