**Exchange Visitor Information**

*Please add your information electronically using a computer. Do not add information by hand. Please save and return the document in Word or PDF format.*

|  |  |
| --- | --- |
| **1. Personal Information** |  |
| Family Name: | Given Name: | Middle Name: |
|       |       |       |
| Gender: | Date of Birth: | City of Birth: | Country of Birth: |
| [ ]  Male [ ]  Female | Select Date |       |       |
| Country of Citizenship | Legal Permanent Residence Country: |
|       |             |
| Passport Number: | Date of Issue: | Expiration Date: | Passport Issuing Country: |
|       | Select Date | Select Date |       |
| **1.1 Address and Contact Information** |
| Street/Apt. Address: | City: | Country: | Zip/ Postal Code: |
|       |       |       |       |
| Email Address: | Telephone Number: | Mobile Number: |
|       |       |       |
| Country Code: | Best Time to Call: |
|       |       |
| **1.2 Participation in J-1 Programs** |
| Have you participated in a J-1 program in the past? [ ]  Yes [ ]  No |
| If Yes, provide information: | 1. Name of the program:

**Start Date** until **End Date** |
| 1. Name of the program:

**Start Date** until **End Date** |

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| **2. Marital Information** |  |
| Marital Status: | If Married, will your spouse need a J-2 visa to enter the U.S.? |
| [ ]  Single [ ]  Married**\*if Single, skip section 2.2** | [ ]  Yes [ ]  No **\*if Yes, fill out section 2.2** |
| **2.2 Information about Spouse or Dependent** |
|  Family Name: | Given Name: | Gender: |
|       |       | [ ]  Male [ ]  Female |
| Date of Birth:  | City of Birth: | Country of Birth: |
| Select Date |       |       |
| Do you have any other dependents? | Has she/he been to the U.S.? | Date to enter U.S.: |
| [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | Select Date |

|  |  |
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| **3. Educational Background** |  |
| Are you a fulltime student? | Educational Institution/School Name: |
| [ ]  Yes [ ]  No |            |
| Name of the Degree / Field studied / Course Name: | Date started university: |
|            | Select Date |
| Field of Studies Degree Equivalent (Associate’s, Bachelor’s, Master’s, etc.): | Estimated or actual graduation date: |
|            | Select Date |

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| **4. Information about Work Experience / Employment** |  |
| Are you employed? | Name of company: | Address of Company: |
| [ ]  Yes [ ]  No |       |       |
| Current position: | Name of supervisor: | Telephone number: |
|       |       |       |
| Computer programs familiar with: |       |
|  |
| **5. Emergency Contact Information** |  |
| 1. Name:
 | Phone Number: | Another Phone Number: | Relationship: |
|       |       |       |       |
| Country: | English Speaking? | If no, what language? | Email Address: |
|       | [ ]  Yes [ ]  No |       |       |
| 1. Name:
 | Phone Number: | Another Phone Number: | Relationship: |
|       |       |       |       |
| Country: | English Speaking? | If no, what language? | Email Address: |
|       | [ ]  Yes [ ]  No |       |       |
| 1. Name:
 | Phone Number: | Another Phone Number: | Relationship: |
|       |       |       |       |
| Country: | English Speaking? | If no, what language? | Email Address: |
|       | [ ]  Yes [ ]  No |       |       |
| *\*You MUST provide at least* ***3 emergency contacts*** *and:**2 family members and 1 non-family member. All emergency contacts will be verified before departure so please include valid information.* |

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| **6. Criminal and Health Background** |  |
| Have you ever been convicted of a crime? | [ ]  Yes [ ]  No |
| If Yes, please explain:      |
| Please select any of the following conditions which currently apply to you or which you feel could impact your program. |
| Dyslexia: | [ ]  Yes [ ]  No | Whooping Cough: | [ ]  Yes [ ]  No |
| Physical Handicap: | [ ]  Yes [ ]  No | Asthma: | [ ]  Yes [ ]  No |
| Scarlet Fever: | [ ]  Yes [ ]  No | Convulsive Disorder: | [ ]  Yes [ ]  No |
| Psychological Disorder: | [ ]  Yes [ ]  No | Hepatitis | [ ]  Yes [ ]  No |
| Measles: | [ ]  Yes [ ]  No | Urological Problems: | [ ]  Yes [ ]  No |
| Ulcer: | [ ]  Yes [ ]  No | Cancer/Tumors: | [ ]  Yes [ ]  No |
| Migraine Headaches: | [ ]  Yes [ ]  No | Eating Disorder: | [ ]  Yes [ ]  No |
| Substance Abuse: | [ ]  Yes [ ]  No | Eczema: | [ ]  Yes [ ]  No |
| Thyroid Disease: | [ ]  Yes [ ]  No | Chicken Pox: | [ ]  Yes [ ]  No |
|  Rheumatic Fever: | [ ]  Yes [ ]  No | Rubella: | [ ]  Yes [ ]  No |
| Diabetes: | [ ]  Yes [ ]  No | Mumps: | [ ]  Yes [ ]  No |
| Allergy: | [ ]  Yes [ ]  No | **Other conditions:**  |  |
| Do you require special consideration?[ ]  Yes [ ]  No |
| **If Yes, please explain the treatment:** |       |
| Do you need to take any prescribed and/or long-term medication during stay:[ ]  Yes [ ]  No |
| **If Yes, please explain the treatment:** |       |

[ ]   I understand that my insurance coverage does not cover any preexisting conditions and
     if medical treatment is needed it is my responsibility to pay all fees incurred in full.

[ ]  I understand that it is my responsibility to purchase additional insurance to cover any preexisting conditions.