

## REQUEST FOR FORM DS-2019 for J-1 EXCHANGE VISITORS

The Department of State (DOS) regulates all Exchange Visitor programs in the United States. At SUNY Upstate Medical University, the Office of Graduate Medical Education is responsible for the J-1 visa exchange visitor program. The objective of this visa is to increase mutual understanding between the people of the United States and the people of other countries by means of educational and cultural exchange.

Our department has to send the exchange visitor a form called an DS-2019. They must take this DS-2019 to a U.S. embassy or consulate in their country to obtain their J-1 visa. An exchange visitor who is entering our country to do research on a J-1 visa may stay in the United States for a maximum of five years.

The DOS regulations require that, prior to issuing Form DS-2019, the sponsor must verify that the potential exchange visitor: 1) Is eligible, qualified, and accepted for the program in which s/he will be participating; 2) Has English language skills necessary to complete the program, which may include a period of language study; 3) Has health insurance which meets the requirements set forth by the DOS; 4) Possesses adequate financial resources to complete the program; 5) Possesses adequate financial resources to support any accompanying dependents.

You, as the inviting department, are most qualified to determine whether or not the potential exchange visitor possesses adequate academic knowledge and work experience necessary to participate in your project or as a student at our institution.

**PLEASE NOTE:** A research scholar who enters our country on a J-1 visa may only participate in the activities specifically stated on the DS-2019 and may only perform these activities at the location noted on the DS-2019. This means that your research scholar is not permitted to go to any other institution except SUNY Upstate Medical University unless they are legally transferred to another institution. This transfer has to be done through our office.

The amount of funding received by the J-1 exchange visitor must be of an adequate amount to cover ALL costs associated with his/her stay in the U.S., including the mandatory health insurance as required by the Department of State. Minimum standards established for our institution are:

J-1 exchange visitor:	\$22,000/year (\$1,835/month)
J-2 dependent(s):	Additional \$4,200/year for <b>each</b> J-2 dependent (\$350/month)

If a research scholar has to purchase health insurance through our institution, the costs are:

J-1 exchange visitor:	\$95.50 per month
J-2 spouse:	\$204.60 per month
J-2 children:	\$110.20 per month

This insurance runs from the 15<sup>th</sup> of one month to the 15<sup>th</sup> of the next month.

Exchange visitors should arrive in the United States on or before, but no more than 30 days before, the program start date on Form DS-2019. If the exchange visitor enters within 30 days after the program start date, they should not have a problem in being admitted to the United States. If their entry will be delayed beyond 30 days, let our office know as their start and end dates will have to be amended via our Student and Exchange Visitor Information System.

**Research Scholar Information**

Please write the name exactly as shown on passport:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Initial Sponsorship Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_

Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City of Birth: \_\_\_\_\_

Country of Birth: \_\_\_\_\_

Current Citizenship: \_\_\_\_\_

Legal Permanent Resident of: \_\_\_\_\_

Position in Home Country: \_\_\_\_\_

Degree Earned: \_\_\_\_\_

Research Scholar Foreign Address (including zip code:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Foreign Home Telephone #: \_\_\_\_\_

Foreign Office Telephone #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Fax #: \_\_\_\_\_

Social Security Number\* \_\_\_\_\_

Driver's License Number\* \_\_\_\_\_

Individual Taxpayer ID Number\* \_\_\_\_\_

\*If available

**Hiring Department Information:**

Department Name \_\_\_\_\_

Contact Person and Phone #: \_\_\_\_\_

Supervisor and Phone #: \_\_\_\_\_

Travel companions (immediate family only):

First Name	Last Name	Relationship	Date of Birth	City and Country of Birth

Please provide a brief, clear description of what activities the exchange visitor will undertake when at our institution:




## **INCIDENTAL PATIENT CONTACT vs NO PATIENT CONTACT**

This applies to foreign PHYSICIANS only. If your researcher is not a physician, do not complete either form. GO TO LAST PAGE.

Academic departments wishing to bring a foreign medical physician as an exchange visitor to SUNY Health Science Center for research should read the attached statements to determine which of the two is appropriate regarding the primary purpose of the exchange visitors' participation in our program.

The **INCIDENTAL PATIENT CONTACT STATEMENT** is to be used for alien physicians who will have **INCIDENTAL PATIENT CONTACT** under the direct supervision of a physician who is a US citizen or resident alien and who is licensed to practice medicine in the State of New York.

The **NO PATIENT CONTACT** statement is to be used for alien physicians who will have **NO PATIENT CONTACT OF ANY KIND**.

**Do not complete and sign both forms. Only one form** is appropriate for the purpose of the exchange visitors visit. If the appropriate contact statement is not completed and signed, a Form DS-2019 will not be issued

**REMEMBER THESE FORMS ARE FOR FOREIGN PHYSICIANS ONLY. If the exchange visitor IS NOT A PHYSICIAN, YOU CAN SKIP TO THE LAST PAGE.**

**INCIDENTAL PATIENT CONTACT STATEMENT**

FOR FOREIGN PHYSICIANS ONLY - If you complete this page, do not complete Page 7. If the exchange visitor is not a PHYSICIAN, you can skip to the last page.

The Office of Graduate Medical Education is designated as the office responsible for the State University of New York Health Science Center at Syracuse's Exchange Visitor Program. This office will issue the Form DS-2019 to an alien physician for the purpose of observation, consultation or research. To assure that the exchange is non-clinical, GME requests that the following statement be completed and signed by the inviting supervisor and the Dean of the College of Medicine.

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The program in which \_\_\_\_\_ will participate is predominantly involved with observation, consultation or research. Any incidental patient contact involving the alien physician will be under the direct supervision of a physician who is a U.S. citizen or a resident alien and who is licensed to practice medicine in the State of New York. The alien physician will not be given final responsibility for the diagnosis and treatment of patients. Any activities of the alien physician will conform fully with the state licensing requirement and regulations for medical and health care professionals in the State of New York. Experience gained in this program will not be creditable towards any clinical requirements for medical specialty board certification.

Supervisor/Department	Date
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Steven Scheinman, M.D. Dean, College of Medicine	Date
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RO/ARO of Program P-1-3856	Date
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**NO PATIENT CONTACT STATEMENT**

**Important note:** If you complete this page, do not complete Page 6. THIS FORM IS FOR FOREIGN PHYSICIANS ONLY. If the exchange visitor IS NOT A PHYSICIAN, you can skip to the last page.

The Office of Graduate Medical Education is designated as the office responsible for the State University of New York Health Science Center at Syracuse's Exchange Visitor Program. This office will issue the Form DS-2019 to an alien physician for the purpose of observation, consultation or research. To assure that the exchange visitor will have NO PATIENT CONTACT, GME requests that the following statement be completed and signed by the inviting supervisor.

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"The program in which \_\_\_\_\_ will participate is solely for the purpose of observation, consultation or research and that **no element of patient care services is involved.**"

<b>Supervisor/Department</b>	<b>Date</b>
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<b>RO/ARO of Program P-1-3856</b>	<b>Date</b>
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Please read the following:

I have invited the aforementioned potential exchange visitor to my department for the purpose stated on page 3 of this Request. I have reviewed the academic background and work experience of this exchange visitor. I hereby verify that he/she possesses adequate academic knowledge and work experience to participate in the activities that are integral to the purpose stated on page 3 of this Request.

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DEPARTMENT SUPERVISOR

DATE

PHONE #

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DEPARTMENT NAME AND ADDRESS

PLEASE INCLUDE THE FOLLOWING DOCUMENTS WITH THIS REQUEST:

1. CV
2. Copy of passport
3. If the person is currently in the U.S. on a J-1 visa, a copy of J-1 visa, I-94 card and DS-2019

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Please return the entire request (with attachments) to:

Mary Jo DiNuzzo  
Graduate Medical Education, 1814UH  
SUNY Upstate Medical University  
750 East Adams Street  
Syracuse, NY 13210  
Phone number: 315-464-5861  
Fax number: 315-464-7619

After reviewing your request, a Form DS-2019 will be completed and forwarded with an information packet directly to the exchange visitor.

Request