

TO BE COMPLETED BY
VISITING PROGRAM
PARTICIPANT

Contact Information

YOUR NAME

Family Name: _____

Given Name: _____

Date of Birth (Month/Day/Year): _____

PERMANENT ADDRESS IN HOME COUNTRY

Street: _____

Street #2: _____ Apartment Number (if applicable): _____

City: _____ Region/Province/State: _____

Country: _____ Zip/Postal Code: _____

LOCAL U.S. HOME ADDRESS

NOTE: A physical street address is required.

Street (Number and Name): _____ Apartment Number (if applicable): _____

City: _____ State: _____

Zip/Postal Code: _____ Local Telephone: _____

Email: _____ Email of spouse (if in J-2 status): _____

NIH Email (if known): _____ Work/Office Telephone (if known): _____

If your dependents are in J-2 status, will they also reside at this U.S. residential address?

- YES
 NO [NOTE: If you select "NO," provide address on a separate sheet of paper]
 N/A – No Dependents

IN CASE OF EMERGENCY

Family Name: _____ Given Name: _____

Telephone: _____ Email: _____

Relationship to you: _____ Preferred Language (if does not speak English): _____

CONSENT TO ACCESS FORM I-94 ARRIVAL/DEPARTURE RECORD

By checking-in with the Division of International Services (DIS), you give us your consent to access your and your dependent(s)'s Form I-94 Arrival/ Departure record from the U.S. Customs and Border Protection (CBP) [I-94 website](#) to facilitate your check-in at the NIH. This consent will remain valid as long as you are an active participant at the NIH.

(REQUIRED) Signature: _____

(REQUIRED) Date (Month/Day/Year): _____