INTERNSHIP USA/PROFESSIONAL CAREER TRAINING USA

J-2 DEPENDENT APPLICATION

J-2 Applicant Last Name: J-2 Applicant First Name:

J-1 APPLICANT

Last name: First name:

Program Start Date (mm/dd/yyyy): Program End Date (mm/dd/yyyy):

INSTRUCTIONS AND CHECKLIST FOR J-2 DEPENDENT APPLICATION

A dependent is a spouse or an unmarried child (under 21 years of age) who will be accompanying the J-1 Exchange Visitor to the U.S. The Certificate of Eligibility (DS-2019 Form) for a J-2 dependent only allows for the dependent to travel with the J-1 Exchange Visitor. As the primary J-1 Exchange Visitor, it is your responsibility to prove financial support for each J-2 dependent in the amount of $1000.00 per J-2, per month in the U.S.

In order to provide a DS-2019 for the J-2 dependent, CIEE requires the following:

- ☐ A complete biographical information section on each dependent (below)
  Please submit additional pages if you have more than two dependents.
- ☐ A copy of a valid passport for each dependent
- ☐ Proof of dependent status: marriage certificate for spouse; birth certificate for child
- ☐ Proof of financial support for each J-2 dependent in the amount of $1000.00 per dependent, per month

J-2 DEPENDENT

Last name: Gender: ☐ Female ☐ Male

First name: Date of birth (mm/dd/yyyy):

Middle name: Contact Number while in U.S.:

Relationship to Applicant: ☐ Spouse ☐ Dependent Child (under 21 years of age) Email:

Date of departure to U.S. (mm/dd/yyyy): Date of return to home country (mm/dd/yyyy):

City of birth: Country of birth:

Country of citizenship: Country of legal permanent residence:

Passport number: Passport expiration date (mm/dd/yyyy):

J-2 DEPENDENT

Last name: Gender: ☐ Female ☐ Male

First name: Date of birth (mm/dd/yyyy):

Middle name: Contact Number while in U.S.:

Relationship to Applicant: ☐ Spouse ☐ Dependent Child (under 21 years of age) Email:

Date of departure to U.S. (mm/dd/yyyy): Date of return to home country (mm/dd/yyyy):

City of birth: Country of birth:

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CULTURAL EXCHANGE

What American cultural activities do you hope to participate in while in the U.S?
These can be activities that you plan to participate in with your J-1 or on your own. (Please disregard this question if the J-2 is a minor.)

APPLICANT CONFIRMATION

I (print your name), _____, certify that the information provided on the J-2 dependents is true and correct.

Applicant Signature: _____ Date (mm/dd/yyyy): _____

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FEE DISCLOSURE (fees that will be collected by the CIEE International Representative, CIEE or the U.S. Government)

Fee	Amount (Please specify currency:)	Inclusions
Program fee	1 month: _____ 2 months: _____ 3 months: _____ 4 months: _____ 5 months: _____ 6 months: _____ 7 months: _____ 8 months: _____ 9 months: _____ 10 months: _____ 11 months: _____ 12 months: _____ 13 months: _____ 14 months: _____ 15 months: _____ 16 months: _____ 17 months: _____ 18 months: _____ 19 months: _____ 20 months: _____	- Application fee - Agent support pre-departure - U.S. Sponsor support - Orientation - Screening for program - Administrative costs - Insurance Plan (for policy details visit www.ciee.org/insurance)
Visa interview fee		- U.S. government administrative cost
Promotion		- Discount
Placement fee		- All costs related to finding a placement
Expedite fee		- Expedited forms and/or application review
Other services		
Total fees (excluding airfare, housing, & transportation)		
Flight (estimated cost)		- Round-trip airfare (this is the typical cost – actual price will depend on destination and dates selected)
Housing fee (estimated cost)		- This is the typical cost – actual price will depend on location
Transportation fee (estimated cost)		- This is the typical cost – actual price will depend on location

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FEE DISCLOSURE (continued)

Cancellation and refund policy:

Other program costs and pricing notes:

PARTICIPANT FEE AGREEMENT (to be signed by J-1 Applicant or J-2 Applicant, if J-2 Applicant is not a minor)

I confirm that I have reviewed the complete pricing information in this document and fully understood the costs of the program before I paid a non-refundable deposit.

Name Printed:

Signature: Date (MM/DD/YYYY):

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MEDICAL HISTORY

(Please complete this section to the best of your ability, noting that your responses will have no impact on whether or not your application is approved for your internship/training program)

Have you ever been hospitalized? ☐ Yes ☐ No If yes, please explain:

Have you ever been advised to have surgery which has not been done? ☐ Yes ☐ No If yes, please explain:

Have you ever consulted a neurologist, psychiatrist, psychologist, or any other specialist in nervous or emotional disorders? ☐ Yes ☐ No
If yes, please explain:

When, and for what reason, did you last consult a physician?

What diseases, ailments, or injuries have you had in the last year?

Please mention any allergies, the severity of the allergy, and indicate if and how they are currently being treated.

Do you have any physical limitations? ☐ Yes ☐ No If yes, please explain:

Please indicate any medication you are currently taking and the purpose of using these drugs. (Note: A supply of medication should be taken in clearly labeled containers indicating the drug's generic name.)

If you are allergic to any drugs or medications, please list them here.

Please indicate any other pertinent medical information that may have been omitted. (such as abnormal blood pressure, weight problems, etc.)

PRIVACY, HIPAA, AND CONFIDENTIALITY RELEASE FORM

By completing this form, you give consent to CIEE, your parents or guardian, your physicians and/or other medical providers to discuss your medical and/or insurance issues with CIEE. You also consent to CIEE utilizing any such material in, and as necessary in, treating any medical condition which may arise. You also consent that CIEE may notify your emergency contact listed in this application of any situation that we deem to be an emergency. In addition, you consent that CIEE may notify the official CIEE designated agency from whom you purchased this program of any situation that we deem to be an emergency.

This authorization is valid for two years from the date signed.

Under no circumstances can CIEE release medical information from your physician or provider of service to you or anyone. Your medical information has been disclosed to us from your physician or provider of service and we are prohibited by federal law from further disclosure. Please contact your physician or provider of service for your medical information.

I give CIEE permission to release any or all of the following information in and as appropriate in the event of a medical condition.
(Please initial and check each box.)

Initial: _____ ☐ All financial and claim information related to medical bills or Claimant's Statement and Authorization.
Initial: _____ ☐ Provide name, date of service, total charge, total paid, and date of payment.
Initial: _____ ☐ Insurance ID number and/or social security number.

Print Patient Name:

Signature of the Patient, Adult Parent, or Legal Guardian:

Date (mm/dd/yyyy):