Notification of Arrival Form

Please complete and upload this form to the portal within 10 days of program start date.

ARRIVAL INFORMATION

1. Name: _____

2. Country: _____

3. Date of departure from home country: _____
   Month Day Year

4. Date of arrival in the United States: _____
   Month Day Year

5. Start date of grant activities at host institution: _____
   Month Day Year

6. End date of grant activities at host institution: _____
   Month Day Year

7. Verification of grant start date *(Please have a representative from your host institution verify the start date of your full-time Fulbright grant activities.)*: ☐ Faculty Associate ☐ Other Institutional Official

_____
Name of Representative

_____
Host Institution Department

_____
City State

_____
Signature Date

DEPENDENT AND INSURANCE INFORMATION

8. Under certain U.S. federal, state, county, and local laws, J-1 Visa holders or their dependents may seem to qualify for "public assistance" (such as health insurance, subsidized housing, food assistance, and unemployment benefits). Please be aware that accepting these benefits is not permissible, may jeopardize your status as a nonimmigrant visitor in the U.S., make you eligible for deportation, and prevent you from re-entering the U.S. in the future.

   I acknowledge the public assistance understanding. _____
   Signature Date

9. If no dependents will accompany you, sign the line below to confirm:

_____
Signature Date

If dependents have accompanied or will join you in the United States, complete dependent arrival information on Page 2.

Notification of Arrival Form

Name: _____ Country: _____

DEPENDENT INFORMATION (continued)

The following members of my family are with me or will be joining me in the United States.

	Last Name, First Name	Expected Date of Arrival in the U.S. (Month Day Year)	Expected Date of Departure from the U.S. (Month Day Year)
Spouse			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			

J Visa Exchange Visitor regulations require that you provide health insurance coverage for all J-2 dependents who are with you in the United States. This coverage must be in effect during the full period of stay while they remain in the United States and must meet the minimum requirements set forth by the U.S. Department of State (see Part II: Section 11 of the *Guide for Fulbright Visiting Scholars*).

MЛ. Please provide the name of the insurance carrier providing health insurance coverage for your dependents:

_____

Health Insurance Provider

NOTE: Failure to provide necessary health insurance coverage for all dependents in the United States may lead to grant termination. If you have not yet arranged for coverage, do so immediately. Consult the ***Guide for Fulbright Visiting Scholars*** for a list of insurance carriers offering plans that meet J visa requirements. If your dependents will not be arriving with you, IIE/CIES must receive confirmation of purchase no more than 30 days following the arrival of your dependent(s).

I agree to comply with J visa health insurance requirements for my dependents.

_____

Signature Date

The Power of International Education

Health Information Release Form

IIE/CIES administers the Fulbright Program under a contract with and on behalf of the United States Department of State. As the contractual administrative agency, IIE/ CIES, through its authorized employees, agents, representatives and designees ("IIE/CIES personnel"), is responsible for monitoring your progress in your academic program and your associated visa status.

Your signature on your Fulbright Terms and Conditions of Grant indicates that you understand that throughout your Program you will be required to share information with IIE/CIES that is pertinent to your Program and your continued stay in the United States. For example, you are expected to promptly inform IIE/CIES if you experience any change in your circumstances that could negatively impact your academic performance in your Program; your full-time participation in your Program; or the satisfactory completion of your Program.

In the event of an emergency during your Program participation in the United States, you may need the services of professionals, including but not limited to physicians, nurse practitioners, hospitals, college/university health centers and counseling centers. Health care providers are required by United States law to keep your health-related information confidential and cannot release information to third parties without your written authorization.

Your signature on this form is an acknowledgement and understanding that in a health-related emergency, you authorize the release of your personal health related information to IIE/CIES personnel. This personal health-related information includes, but is not limited to, diagnoses and prognoses, emergency treatment reports, medical records, mental health records (excluding psychotherapy notes), discharge summaries, laboratory reports, progress notes, consultations and evaluations, outpatient clinic reports and alcohol and drug abuse information. You further understand that we may share this information with the employees, agents and representatives of the United States Department of State, of the Accident and Sickness Program for Exchanges (ASPE) and/or of the Fulbright Program in your home country, and, in IIE/CIES's reasonable judgment, other individuals who have a need to know such information.

By signing below, I authorize the release of all my personal health-related information and records in the event of an emergency, as determined by IIE/CIES in its sole discretion. I am also prepared at all times to furnish IIE/CIES personnel with any health-related information relevant to my status as a Program participant as described above.

Signature: _____ Date: _____

Home Country: _____

U.S. Institution: _____