ISSS International Student & Scholar Services

UNIVERSITY OF MINNESOTA

J-1 SCHOLAR SERVICE REQUEST FORM

FOR RESEARCH SCHOLARS, PROFESSORS, SHORT-TERM SCHOLARS AND STUDENT-INTERNS

GENERAL INFORMATION

Scholar/student-intern should complete the section below.

1. Name _____ (Family name) _____ (First name) _____ (Middle)

2. U of M ID# _____ 3. SEVIS ID # _____

4. Email _____ 5. Phone _____

6. Birthdate _____ (Month Day Year) 7. Country of Citizenship _____

8. DS-2019 expiration date _____ (Month Day Year) Passport expiration date _____ (Month Day Year)

Visa expiration date _____ (Month Day Year)

9. Has financial information changed? ☐ Yes (submit additional application) ☐ No

10. Has internship changed (student-interns only)? ☐ Yes (submit additional application) ☐ No

10. If J-2 dependent exists, are they still in the U.S.? ☐ Yes ☐ No ☐ N/A

REQUEST

Scholar/student-intern should complete the section below.

Please check appropriate response:

☐ Travel Signature for Reentry on DS-2019. *Destination:* _____ *Travel Dates:* _____

☐ Check if you or anyone on your behalf filed for or received legal permanent residency (green card)

☐ Check if you are traveling *without* your J-2 dependents

☐ Travel Signature for Reentry on Dependent DS-2019

☐ Replacement - check one: ☐ lost ☐ stolen ☐ damaged ☐ travel

☐ Other, please specify _____

By signing below, I certify that the information I have provided on this form is complete and accurate. The University of Minnesota requires all international scholars, student-interns, and accompanying dependents to purchase a University of Minnesota health insurance plan. Authorized exceptions to this requirement are issued in form of a waiver by the Office of Student Health Benefits. I and any eligible J-2 dependents have the following insurance plan - Check one:

☐ *University of Minnesota Student Health Benefit Plan - SHBP (Office of Student Health Benefits: 612-624-0627)*

☐ *University of Minnesota employee UPlan (HR Employee Benefits: 612-624-9090)*

☐ *Other U.S.-based employer-sponsored health plan approved ("waived") by the Office of Student Health Benefits*

_____ (Signature) _____ (Month Day Year)

ISSS will complete this section:

☐ Verified information on form, discussed travel (if applicable)

☐ I-94 admission stamp shows J-1 D/S

International student adviser initials _____

Adviser Comments _____

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(612) 626-7100 ● Fax (612) 626-7361 ● isss@umn.edu ● isss.umn.edu

Ready by: _____

11/2016