Notification of Arrival Form

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

1. ARRIVAL DETAILS

Name:

Country:

Date of departure from home country:

Date of arrival in the United States:

Start date of grant activities at host institution:

End date of grant activities at host institution:

2. INSTITUTIONAL HOST 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:

Department:

Institution:

Address:

City State:

Email:

***SIGNATURE OF FACULTY ASSOCIATE/INSTITUTIONAL OFFICIAL:** _____ **DATE**

3. NOTICE ON PUBLIC ASSISTANCE

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 OF FULBRIGHTER** _____ **DATE**

4. DEPENDENT DISCLOSURE (Choose one)

☐ **I am not accompanied by any dependents on my Fulbright Exchange.**

***SIGNATURE OF FULBRIGHTER** _____ **DATE**

☐ **I am bringing dependents with my on my Fulbright Exchange** → Proceed to next page and complete arrival information.

**Ink, electronic, and typed signatures are all accepted. I agree that any representation of my signature submitted is legally binding for agreements, terms and conditions of award and other documents IIE requests requiring my signature. I acknowledge and consent that these signatures have the same legal validity and effect as my handwritten signature and that it has the same meaning as my handwritten signature.*

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5. DEPENDENT ARRIVALS AND INSURANCE INFORMATION

Important note: J Visa Exchange Visitor regulations require that you provide/purchase health insurance coverage for all J-2 dependents who are with you in the United States. Fulbright's ASPE insurance (administered by Seven Corners) only covers you as the Fulbright grantee. Your dependents are **not** covered through Fulbright Program ASPE health benefits although you ***may purchase*** Seven Corners coverage on your own for your dependents. You may also purchase any other policy of your choice. This coverage must be in effect during the full period of stay while they remain in the United States. Regardless of the plan/company you choose, the policy you purchase must meet the minimum requirements set forth by the U.S. Department of State:

- Medical coverage of at least $100,000 per person per accident or illness;
- repatriation of remains in the amount of $25,000;
- medical evacuation benefits of at least $50,000;
- a deductible that does not exceed $500.

Please provide below the names of the members of your family who are joining you in the United States and are sponsored by IIE as **J2 visa holders**, as well as the insurance carrier providing their health insurance coverage and the dates of their policies. If your dependents are coming on a visa other than a Fulbright-sponsored J2, or are U.S. citizens, do not list them here, but note them in the second chart below.

J-2 Dependent Type	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)	Health Insurance Carrier Name
Spouse					
Child					
Child					
Child					
Child					
Child					

NOTE: Failure to provide necessary health insurance coverage for your J-2 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 must receive confirmation of purchase no more than 30 days following the arrival of your dependent(s).

NOTE: You are required to inform IIE of any changes to the status of your J-2 dependents, including but not limited to separation and/or divorce, final departure from the U.S., and changes to visa type. In the event that an accompanying dependent on a J-2 visa is pregnant or becomes pregnant while in the U.S., the grantee is required to provide proof of appropriate medical insurance that covers pregnancy and childbirth in the U.S. Failure to provide proof of appropriate insurance may result in termination of the grant.

See the *Guide for Fulbright Visiting Scholars* and refer to your Terms and Conditions document for more information on insurance requirements and your responsibilities for your dependents.

☐ **I agree to comply with J visa health insurance requirements for my J-2 dependents.**

***SIGNATURE OF FULBRIGHTER** _____ **DATE** _____

6. NON-J-2 DEPENDENT INFORMATION:

Please provide the names and information for any dependents that are joining you during your program but will not be sponsored as J-2 dependents during your Fulbright exchange. Please note that you are responsible for securing any necessary health insurance coverage for these dependents.

Dependents on Non-J-2 Statuses	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)	Visa Type (or indicate if U.S. Citizen)	Comments
Spouse						
Child						
Child						
Child						

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The Power of International Education

Health Information Release Form

IIE administers the Fulbright Program under a contract with and on behalf of the United States Department of State. As the contractual administrative agency, IIE, through its authorized employees, agents, representatives and designees ("IIE 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 that is pertinent to your Program and your continued stay in the United States. For example, you are expected to promptly inform IIE 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 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'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 in its sole discretion. I am also prepared at all times to furnish IIE personnel with any health-related information relevant to my status as a Program participant as described above.

*Signature: _____ Date: _____

Home Country: _____

U.S. Institution: _____

**Ink, electronic, and typed signatures are all accepted. I agree that any representation of my signature submitted is legally binding for agreements, terms and conditions of award and other documents IIE requests requiring my signature. I acknowledge and consent that these signatures have the same legal validity and effect as my handwritten signature and that it has the same meaning as my handwritten signature.*