

REQUEST FOR FORM DS-2019
FOR USE BY PROFESSOR OR RESEARCH SCHOLAR
AT BUCKNELL UNIVERSITY

PART I –DEPARTMENT INFORMATION

1. Host Department: _____
2. Department Address & Phone: _____
3. Title of Position: _____
4. Budget number to charge the cost of mailing documents _____ - _____
Name of account _____.

PART II – PROFESSOR/RESEARCH SCHOLAR INFORMATION

5. Name: _____
Family name Given name (include middle name)
6. Male/Female: _____
7. Date of Birth: _____
month/day/year
8. Place of Birth: _____
City Country
9. Citizen of: _____
City Country
10. Legal Permanent Resident of: _____
11. Does this Visitor have a Social Security Number or an ITIN #? (Yes/No) _____
If yes: _____
Social Security Number
If yes: _____
ITIN
12. Highest degree received (check one): _____ Ph.D. _____ other
If not Ph.D., give date and actual name of degree (not US equivalent):
13. Has the applicant held J-1 or J-2 immigration status at any institution in the past 12 months?
If yes, give dates and locations of all visits in last 12 months:

(If currently in the U.S. attach copies of all previous DS-2019 forms)
14. Has applicant visited Bucknell University before? (Yes/No) _____
If yes, give most recent dates: _____

15. Will applicant be accompanied by spouse or children? (Yes/No) _____

If so, please list: a)name, b)date of birth c)citizenship and d)city of birth of each family member.

16. Mailing Address (please include a postal code if applicable)

17. E-mail Address: _____

18. Telephone number and Fax number: _____ (Fax) _____

PART II – HEALTH INSURANCE INFORMATION

19. He/She ____ will ____ will not (check one) be eligible for staff benefits including employee insurance paid through payroll deduction.

20. Host Department ____ will ____ will not (check one) pay for health insurance arranged for by Bucknell.

21. Host Department ____ will ____ will not (check one) pay for health insurance for family members accompanying visitor.

Approved by Department Head, Host Department

Signature

Date: _____

Print Name: _____

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