FORM I-644: SUPPLEMENTARY STATEMENT FOR GRADUATE MEDICAL TRAINEES

U.S. Department of Justice
Immigration and Naturalization Service

Supplementary Statement For
Graduate Medical Trainees

Affidavit for Exchange Visitor who seeks an extension of stay in order to complete a program of graduate medical education and training.

OMB No.1115-0108
Approval expires 9/85

This form must be completed and submitted to the Immigration and Naturalization Service every year for each Foreign Exchange Visitor seeking an extension of stay in order to complete a program of graduate medical education and/or training. The collection of this information is required by Public Law 97-116.

PART 1 To be Completed by Exchange Visitor

I certify that I am in good standing in a program of graduate medical education or training, under the exchange visitor program number indicated below, and that I will return to my country of nationality or last foreign residence upon completion or termination of my participation in the program. I also understand that I must reside in that country for at least two (2) years before I can qualify for an immigrant visa to the United States or for classification as an "H" or "L" nonimmigrant temporary worker.

My name is (please print) _____ ECFMG No: _____
I am in the Exchange Visitor Program No: P-3-4510
My field of study is _____
My country of nationality is _____
My country of last foreign residence is (OTHER THAN THE U.S.A.) _____
I intend to work in the activity or medical specialty of _____
My residential address is _____

I declare and certify under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on (Date) _____ Signature _____

PART 2 To be Completed by Institutional Director of Graduate Medical Education or Training Program

I certify that the graduate medical student or trainee named in Part 1 is in good standing in the Exchange Visitor Program identified and that the information he or she provided is true and correct to the best of my knowledge.

Name of program director (please print) _____

Exact title of program director _____

Name of institution _____

Address of institution _____
Street Name and Number City and State Zip

Executed on (Date) _____ Signature _____

Form I-644 (11-1-82) **GPO 894-809**

PLEASE NOTE:

- **Every line must be completed.**
- The response to **"My country of last foreign residence is (OTHER THAN THE U.S.A.)" in Part 1** should match the source country of the Statement of Need. The Statement of Need submitted to ECFMG at the time of initial application establishes and confirms an applicant's country of last foreign residence.
- The response to **"My residential address is" in Part 1** needs to match your residential address listed in OASIS.
- **Part 2** of Form I-644 must be completed by the program director or the director of graduate medical education at the current or most recent (not proposed) host institution.