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.

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)

Form I-644 is an attestation of the exchange visitor physician’s good standing in the Exchange Visitor Program as of his/her participation in his/her most recent host program. It must, therefore, be completed by the program director or the director of graduate medical education at the current, or most recent (not proposed) host institution.