

Access ID: \_\_\_\_\_ (IFSS only)

**International Faculty & Staff Services**



Office of Human Resources  
University of Wisconsin-Madison

**DEPARTMENT REQUEST FORM**

International Faculty & Staff Services (IFSS)

Phone 608.265.2257 | Fax 608.265.6547

E-mail: [ischolars@ohr.wisc.edu](mailto:ischolars@ohr.wisc.edu) | web: [www.ohr.wisc.edu/ifss](http://www.ohr.wisc.edu/ifss)

Beneficiary's Name: \_\_\_\_\_ Country: \_\_\_\_\_

Beneficiary's Email: \_\_\_\_\_ Empl ID (if known yet): \_\_\_\_\_

Beneficiary's Title (official not working title): \_\_\_\_\_ PVL #: \_\_\_\_\_

Supervisor Name/Email: \_\_\_\_\_

Proposed salary: \$ \_\_\_\_\_ Pay Basis:     A Basis (12 month)     C Basis (9 month)

Percent time of position: \_\_\_\_\_ If less than 100%, please list full time salary: \$ \_\_\_\_\_

Is this employee a foreign medical graduate?     Yes     No

Will the employee's position involve direct patient care?     Yes     No

**Status Requested:**

H-1B

O-1

TN

E-3

**Current immigration status:**

None (outside U.S.)

O-1

E-3

H-1B

TN

Other: \_\_\_\_\_

J-1

F-1 (w/ or w/out OPT)

Date current status expires: \_\_\_\_\_

Anticipated start of this petition: \_\_\_\_\_ Anticipated end of this petition: \_\_\_\_\_

**Type of Petition (please check all that apply):**

New Employment

Change of Employer

Amendment

Change of Status

Concurrent Employment

Extension

**Processing Request:** *Processing times are approximate and do not include Department preparation or IFSS review time (approx. 1-2 months)*

Regular (approx. 5 months)

Premium (15 calendar days)

Department Name: \_\_\_\_\_ UDDS: \_\_\_\_\_

Department Contact Name/email: \_\_\_\_\_

Department Campus Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Back-Up Contact Name/email: \_\_\_\_\_

For IFSS only:

Start of 1<sup>st</sup> H-1B: \_\_\_\_\_ 6 year max will be reached: \_\_\_\_\_ [ Exempt from 6 yr max]

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**Liability for Transportation Costs (H-1B only)**

*Per the Immigration and Nationality Act (INA) 214(c)(5), an H-1B employee who is dismissed from employment by the employer before the end of the period of authorized admission, the employer shall be liable for the reasonable costs of return transportation of the H-1B employee abroad to his/her country of last residence or country of last residence. By signing below, I attest that I understand this regulation and will abide by the provisions stated above.*

**Department Authorization**

*I certify that the above information is correct. I further attest that the position meets the requirements for the above requested visa status and that the beneficiary meets the requirements for the position.*

\_\_\_\_\_  
Name of Supervisor

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Chair

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date