



# NEW INTERNATIONAL STUDENT AND SCHOLAR CHECK-IN FORM

## Turn in Check-in Form with:

### F-Visa Students

- I-20 (Original & Copy)
- Passport (Copy)
- Visa (Copy)
- I-94 ([www.cbp.gov/i94](http://www.cbp.gov/i94))

### J-Visa Students

- DS-2019 (Original & Copy)
- Passport (Copy)
- Visa (Copy)
- I-94 ([www.cbp.gov/i94](http://www.cbp.gov/i94))
- Health Insurance (Copy of Policy in English)

## 1. BASIC INFORMATION

Mr./Ms. \_\_\_\_\_ , \_\_\_\_\_ MI  
Last Name (Family Name) First Name

Student ID: @ \_\_\_\_\_ Birth Date: \_\_\_\_\_

Country of Birth: \_\_\_\_\_ Major: \_\_\_\_\_

Non-IUP E-Mail: \_\_\_\_\_

U.S.A. Phone Number (if available): \_\_\_\_/\_\_\_\_/\_\_\_\_

INDIANA Address: \_\_\_\_\_  
Street Address

City State Zip Code  
(on-campus 15705; off-campus 15701)

## 2. IMMIGRATION INFORMATION

Visa Information: F\_\_\_\_ J\_\_\_\_

Issue Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I-20 or DS-2019

Sevis # N \_\_\_\_\_

Passport

Passport Number: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*I-94 Departure Record - Print at [www.cbp.gov/I94](http://www.cbp.gov/I94)**

### 3. EMERGENCY CONTACT INFORMATION (SPOUSE, PARENT, ETC.)

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Phone Number (if available): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address : \_\_\_\_\_  
Street Address

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

*In case of an emergency, I give the Office of International Education permission to contact the above about my condition.*

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Sign Name

\_\_\_\_\_  
Date (month/day/year)

### 4. RELEASE OF INFORMATION

I hereby authorize Indiana University of Pennsylvania/Office of International Education to release my transcripts and information about my conduct, health, immigration and academic progress to:

Family \_\_\_\_\_

Sponsor \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Sign Name

\_\_\_\_\_  
Date (month/day/year)

### 5. HEALTH INSURANCE REQUIRMENTS FOR J VISA HOLDERS

I understand that it is my responsibility as a J visa holder to maintain sickness and accident insurance and medical evacuation and repatriation insurance that meets or exceeds the minimums set forth in 22 C.F.R. Sec 62.14 by the U.S Department of State. I understand that coverage must be in effect for myself and my dependents for the duration of my exchange visitor status. I agree that willful failure to carry insurance in the required amounts or for the duration of my exchange visitor status is a serious infraction and a violation of the Exchange Visitor Program regulations.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Sign Name

\_\_\_\_\_  
Date (month/day/year)