

STUDENT REGISTRATION FORM

Personal Information:

Name: _____

Name of Dependents: _____

Social Security Number (if applicable): _____

School Identification Number: _____

U.S Address: _____

Phone number: _____

Cell phone number: _____

Foreign Address: _____

Phone Number: _____

Email Address: _____

In case of emergency please contact: _____

Phone number: _____

School Information:

School Affiliation (Please circle one): Medical Dental Sackler

I am currently a full-time student: yes _____ no _____ (if no please contact the International Office)

Source of Support/funding: (ex. personal funds, family funds, student loan, government) _____

I am currently working on campus: yes _____ no _____ (If yes, where and how many hours per week?)

Major or Department Name: _____

Department Phone Number: _____

Anticipated Graduation Date: _____

I plan to apply for Practical Training to work after graduation: yes _____ no _____ (if no, please give reason why):

Please certify the following information:

****I understand that the information above is true and that if there are any changes to any of the above I will notify the International Affairs Office in writing within 10 days of the change. I understand that if I do not notify the International Affairs Office of all changes and comply with the new SEVIS regulations I will be out of status, which will result in possible dismissal from school and possible deportation.**

Please sign and date below.

Signature of Student

Date

Signature of Dependent (if applicable)

Date