

# PERSONAL DATA: F-1 VISA STUDENT

Submit this form, completed, to ISP

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) SEVIS ID# N

Student Name \_\_\_\_\_

Last/Family

First

Middle

Email \_\_\_\_\_ I-20 Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

De Anza Student Identification Number (8 digit #) 

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Social Security Number (9 digit #. Only if you have it) 

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Address (Local U.S.) \_\_\_\_\_

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

Quarter / Year Admitted \_\_\_\_\_/\_\_\_\_\_

Telephone Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ (mm/dd/yyyy)

Admission Number (on I-94): \_\_\_\_\_

Arrival Date in U.S. \_\_\_\_\_ (mm/dd/yyyy)

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

Country of Citizenship \_\_\_\_\_ F-1 Visa Expiration Date: \_\_\_\_\_

Marital Status  Single  Married  Divorced

Spouse Name \_\_\_\_\_

Child Name \_\_\_\_\_

Parents Name (Mother) \_\_\_\_\_ (Father) \_\_\_\_\_

Do one or both of them speak English?  Yes  No (Language \_\_\_\_\_)

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Email \_\_\_\_\_

Financial Sponsor's Name(s) \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Relationship \_\_\_\_\_

COMPLETE BOTH SIDES

# EMERGENCY CONTACT INFORMATION

## Person(s) To Contact In The U.S. In Case Of Emergency

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

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

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

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

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## Person(s) To Contact In Home Country In Case Of Emergency

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Does the person speak English?  Yes  No (Language \_\_\_\_\_) Email: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Does the person speak English?  Yes  No (Language \_\_\_\_\_) Email: \_\_\_\_\_

## Medical Information

Allergies \_\_\_\_\_

Blood Type if Known \_\_\_\_\_

Are you taking any MEDICATION?  Yes  No

Name of Medication \_\_\_\_\_

What is the medical problem? \_\_\_\_\_

## Do You Have Any Special Condition? Please Explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

COMPLETE BOTH SIDES