

Check-In Form

Please complete and send to utoiahouston@uth.tmc.edu or provide to your Advisor at your check-in appointment.

Section 1: Personal Information

Legal LAST/FAMILY NAME

Legal Given Name

Other Names (Preferred Name, Maiden Name, etc.)

Gender (female, male, other)

Marital Status

Date of Birth (MM/DD/YYYY)

City and Country of Birth

Country of Legal Permanent Residency (please list all countries of legal permanent residency)

Country of Citizenship (please list all countries of citizenship)

Section 2: U.S. Immigration Information

Current U.S. (ex: J1, F1, H-1B, TN, E3, etc.)

Date of Last entry into the U.S. (MM/DD/YYYY)

Please use the lines below to provide your complete U.S. Immigration since birth. (Ex: F-1 student from Aug 01 2012 to May 31, 2017; F-1 OPT from June 15, 2017 to June 14, 2018; H-1B from June 15, 2018 to Present, etc.)

Section 3: Personal Contact Information

U.S. Residential Address (include street number, street name, and apartment/unit number, if applicable)

City

State

Zip Code

Cell Phone Number

Home Phone Number

Alternative Phone Number

Pager Number

Permanent Email Address (Gmail, Yahoo, Hotmail, etc.)

Alternative Email Address

Section 4: Dependent Information

Only complete the information below if your dependent's visa is sponsored by UTHealth Houston.

_____ Spouse Child
 Dependent Legal Last Name Dependent Legal Give Name

 U.S. Residential Address (include street number, street name, and apartment/unit number, if applicable)

_____ _____ _____ _____
 City State Zip Code Phone Number

 Dependent email address(es)

_____ Spouse Child
 Dependent Legal Last Name Dependent Legal Give Name

 U.S. Residential Address (include street number, street name, and apartment/unit number, if applicable)

_____ _____ _____ _____
 City State Zip Code Phone Number

 Dependent email address(es)

_____ Spouse Child
 Dependent Legal Last Name Dependent Legal Give Name

 U.S. Residential Address (include street number, street name, and apartment/unit number, if applicable)

_____ _____ _____ _____
 City State Zip Code Phone Number

 Dependent email address(es)

Please use additional pages if you have more than three dependents

U.S. Emergency Contact Information

LAST/FAMILY NAME _____ First/Given Name _____ Relationship _____

U.S. Residential Address: Street _____ Apartment _____ City _____ State _____ Zip Code _____

Telephone Number(s) _____

E-mail Address _____

Home Country Emergency Contact Information

LAST/FAMILY NAME _____ First/Given Name _____ Relationship _____

Residential Address: Street _____ Apartment _____ City _____ Country _____ Postal Code _____

Telephone Number: _____ Home _____ Cell _____ Work _____

E-mail Address _____

By signing below, I hereby certify under penalty of perjury that to the best of my knowledge all of the information contained in this form is true and correct.

I authorize The University of Texas Health Science Center at Houston Office of International Affairs to contact the individuals listed above in the event of an emergency.

Further, if any of the information above changes, I understand that I am required to notify OIA in writing within 10 calendar days.

In the event of an emergency, I authorize the OIA staff to retrieve the Form I-94 for me and any dependents (if applicable) to ensure that OIA has the latest I-94 record on file.

Print Name: _____

Signature: _____ Date: _____