NORTHERN ARIZONA UNIVERSITY

International Student Dependent Form

Center for International Education • PO Box 5598 • Flagstaff, AZ 86011
Telephone: (928) 523-2409 • Fax: (928) 523-9489 • Email: studynau@nau.edu • Website: international.nau.edu

Please complete this form and return it with the requested support documents (including copies of passport data page(s) to the Center for International Education. Only children (including stepchildren) aged 21 and under, and legal spouse can be issued dependent documents. For other accompanying dependents, please contact the nearest U.S. consulate about applying for a "B" tourist visa. Please use additional sheets for more dependents.

Student's Name:_____ **Student ID:**_____

Family Member #1
Names should be the same as they appear in the passport

Family Name: _____
First Name: _____
Middle Name: _____
Relationship to student: _____

Gender: _____

Date of birth: (month/day/year) _____/_____/_____
City of birth: _____
Country of birth: _____
Country of legal Permanent Residence: _____
Country of citizenship: _____

Family Member #2
Names should be the same as they appear in the passport

Family Name: _____
First Name: _____
Middle Name: _____
Relationship to student: _____

Gender: _____

Date of birth: (month/day/year) _____/_____/_____
City of birth: _____
Country of birth: _____
Country of legal Permanent Residence: _____
Country of citizenship: _____

Family Member #3
Names should be the same as they appear in the passport

Family Name: _____
First Name: _____
Middle Name: _____
Relationship to student: _____

Gender: _____

Date of birth: (month/day/year) _____/_____/_____
City of birth: _____
Country of birth: _____
Country of legal Permanent Residence: _____
Country of citizenship: _____

Additional Information

I. Your family's expected date of arrival in the United States: (month/day/year) ____/____/_____
II. Please provide the dollar amount of funding you will have to support your family and attach a bank statement verifying this amount ($5,500 for spouse and $3,500 for each child): _____
III. Please provide the name of the insurance carrier proving health insurance coverage for you dependents:

_____ _____

I CONFIRM MY COMPLIANCE WITH HEALTH INSURANCE REQUIREMENTS AND I UNDERSTAND THAT I AM RESPONSIBLE FOR THE RETURN TRAVEL OF EACH DEPENDENT LISTED.

_____ _____ _____ _____

Signature Date