

## TRANSFER CERTIFICATION

**Part I: To be completed by transferring F-1 student:** "I intend to leave my current US institution and begin study and/or employment at Trinity University. I grant permission for the information requested below to be forwarded to PDSO or DSO at Trinity University."

Legal Name from passport	Date of Birth    ___/___/___ mm    dd            year
Program/Degree	Semester of Admission: <input type="checkbox"/> Summer <input type="checkbox"/> Fall <input type="checkbox"/> Spring
Signature	Today's date    ___/___/___ mm    dd            year

**Part II: To be completed by PDSO or DSO at previous institution:** This international student intends to transfer to Trinity University. Please provide the information at the time of attending your institution, and return via fax and to the address above.

Transferee's name per your files		Has this student been pursuing a full course of study? <input type="checkbox"/> Yes <input type="checkbox"/> No, please comment below
Current I-94 status	Current I-94 Admission number _____	Did U.S.C.I.S. authorize this student to attend your institution? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did this student attend another U.S. institution before yours? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, please specify		Did this student maintain his or hers immigration status at your institution? <input type="checkbox"/> Yes <input type="checkbox"/> No, please comment below
Level of study at this institution: <input type="checkbox"/> High School <input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Language Training <input type="checkbox"/> Other _____		
Dates attended your institution: From ___/___/___ To ___/___/___ mm    dd            year                    mm    dd            year		Studies completed? <input type="checkbox"/> Yes <input type="checkbox"/> No, please comment below
Has this student been granted work authorization? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, please specify  <input type="checkbox"/> Optional Practical Training (OPT) <input type="checkbox"/> Curricular Practical Training (CPT) <input type="checkbox"/> Other _____  From ___/___/___ To ___/___/___ mm    dd            year                    mm    dd            year		Expected completion date on your institution's I-20: ___/___/___ mm    dd            year  SEVIS School Program Code: _____  SEVIS release date: ___/___/___ mm    dd            year  Comments: _____ _____ _____

\_\_\_\_\_  
 Name of PDSO/DSO

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Institution

\_\_\_\_\_  
 Phone number

\_\_\_\_\_  
 Institutional Address

\_\_\_\_\_  
 City, State, Zip code

\_\_\_\_\_  
 e-mail address

\_\_\_\_\_  
 Signature