COLLEGE, CAREER, EQUITY AND SCHOOL CHOICE UNIT – *COUNSELING DEPT.*
Foreign Exchange Program
5100 W Sahara Ave
Las Vegas, NV 89146

CCSD
CLARK COUNTY
SCHOOL DISTRICT

Foreign Exchange Student Health Insurance Verification Form

Student Last Name: _____ First Name: _____

Birth Date: _____ Age: _____ Gender: _____

Parents' Names: _____

This form is to be used by students seeking an F-1 visa who have health insurance in their home countries that can be used in the United States. This form must be submitted with a copy of the health insurance policy card and verification from the insurance company (in English) that the student is covered while living in the United States.

Name of Insurance Company: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Policy and/or Identification Number: _____

Name of Policy Holder: _____

Physician's Name: _____

Physician's Address: _____

_____

Physician's Phone Number: _____ Physician's Fax Number: _____

Read the statement below, sign and date.

I understand that the above named student must maintain this health insurance while an F-1 student attending a school in the Clark County School District. Failure to do so will result in a failure to comply with CCSD policies regarding foreign exchange students and may jeopardize the student's F-1 status.

_____ _____
Parent Signature Date