American Institute of Alternative Medicine
6685 Doubletree Ave. • Columbus, Ohio 43229
ph 614.825.6255 • fax 614.825.6279 • info@aiam.edu

This I-20 Request Form must be completed by any international student seeking a student visa.
Please attach copies of the following documents:

- Passport
- Passport of any dependents

Please send the completed I-20 Request Form to: **American Institute of Alternative Medicine**
ATTN: SEVIS Representative
6685 Doubletree Ave
Columbus, OH 43229
United States of America

_____
Last Name First Name Middle Name (If applicable)

_____Start Date of Program (Quarter/Year)

_____Country of Birth (City, Providence, Country)

_____Date of Birth (mm/dd/yyyy)

_____Country of Citizenship

Foreign Address:

_____

_____
City Providence Country

Address in U.S.:

_____

_____
City State Zip Code

Sex (circle one) Male Female

Mailing Address (if different than above):

_____

_____
City State Zip Code

Please use following page to list dependents that are applying for F-2 Visa. If more space is needed, please copy and fill out another page as needed.

List dependents who are applying for F-2 Visa only:

Relation _____

Last Name _____

First Name _____

Middle Name _____

Date of Birth _____

Sex (circle one) Male Female

Relation _____

Last Name _____

First Name _____

Middle Name _____

Date of Birth _____

Sex (circle one) Male Female

Relation _____

Last Name _____

First Name _____

Middle Name _____

Date of Birth _____

Sex (circle one) Male Female

Relation _____

Last Name _____

First Name _____

Middle Name _____

Date of Birth _____

Sex (circle one) Male Female