



Western University
OF HEALTH SCIENCES
*The discipline of learning.
The art of caring.*

**WESTERN UNIVERSITY OF HEALTH SCIENCES
F-1 STUDENT TRANSFER FORM**

1. Name _____
Last Name First Name Middle Name

2. Date of Birth _____ Country of Citizenship _____

3. U.S. Address: _____

4. Phone _____ E-mail _____

5. Home Country Address _____

I will be transferring to the _____ program at Western University of Health Sciences in _____
(month/year)

I authorize you to provide Western University of Health Sciences with the information below.

Signature _____ Date _____

Please notify your Designated School Official (DSO) and request a release of your records to Western University. The following information must be completed by your DSO.

Name of school transferring from _____

Name of DSO/International School Advisor _____

Phone No. _____ E-mail _____

Date your SEVIS record will be released to Western University _____

Please return this form to the Admissions Office, Western University of Health Sciences, 309 E. Second Street, Pomona, CA 91766-1854. Phone: (909) 469-5335, Fax: (909) 469-5570, E-mail: admissions@westernu.edu.