



Medical Reduced Course Load Provider Recommendation

Student Name: _____ Date of Birth: _____

U.S. law requires international students to enroll for full-time study each fall and spring semester. The student you are meeting with is requesting a Medical Reduced Course Load authorization, stating to have a medical condition preventing him/her from meeting the expectations of a full-time student during the current term. The student is meeting with you to have you evaluate that condition and whether or not it affects his/her ability to continue enrollment in full-time studies. This form should be completed by a U.S. Licensed Medical Doctor, Doctor of Osteopathy, or Licensed Clinical Psychologist only per government regulations.

Please complete this form in its entirety based on your evaluation of the condition. If you support the student's request, you are recommending that the student enroll in part-time studies. ISSS will use this information to determine whether the student is approved for medical reduced course load.

Office Address: _____

Provider's Name: _____ Date of assessment: _____ mm/dd/yyyy

Method of assessment: (select one) In-person Phone Other: _____

- 1. What is the nature of the condition being treated?
2. Date(s) of treatment/assessment: _____ to _____
3. Total number of sessions/appointments: Scheduled: _____ Attended: _____
4. Has the student submitted a release of information form allowing information to be shared with ISSS?
5. Diagnoses related to the concerns of this request: _____
6. Will you continue to provide services for this student? If no, to whom will the student's care be transferred?
7. Is this condition preventing the student from enrolling in full-time studies? If yes, please explain.

8. Does the medical condition impact the types of coursework the student can pursue (eg, student with broken finger may not be able to complete a music performance course)?
- No
 - Yes. Provide further explanation. _____
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9. Based on your evaluation of the student's condition, do you recommend that the student be authorized to enroll below full-time?
- No
 - Yes, I recommend that the student enroll in a reduced course load (part-time studies)
10. Term (select one) Fall Winter Summer Spring Year _____
11. Based on your evaluation of the student's condition, do you believe the student will be able to return to full-time studies next term?
- Yes
 - No. If no, please provide further explanation. _____
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Note: If you are a provider not affiliated with Miami's Student Health Services or Student Counseling Service, we kindly request that you provide the student with a business card in addition to this form.

Provider Signature	Date
Licensed Supervisor Signature (if applicable)	Date
License Number	Title/Degree:
Phone	E-mail

Please complete form in full and email to International Student & Scholar Services or return to the student.

ISSS, 214 MacMillan Hall, Miami University, Oxford OH 45056

Telephone: 513.529.8600 / Email: international@miamioh.edu