MIAMI UNIVERSITY
GLOBAL INITIATIVES
International Student and Scholar Services

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. **Per government regulations, this form should be completed by a licensed medical doctor, psychiatrist, doctor of osteopathy, licensed psychologist, or clinical psychologist based in the United States.**

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?
   - ◻ Mental Health (form completed by a U.S. Licensed Clinical Psychologist)
   - ◻ Physical (form completed by a U.S. Licensed Medical Doctor or Doctor of Osteopathy)
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?
   - ◻ Yes
   - ◻ No
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?
   - ◻ Yes
   - ◻ No ____
7. Is this condition preventing the student from enrolling in full-time studies? If yes, please explain.
   - ◻ No
   - ◻ Yes. Provide further explanation. ____

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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