

## MEDICAL REDUCED COURSE LOAD (MRCL)

The U.S. Citizenship and Immigration Services (USCIS) require non-immigrant students to register full time during the academic year. In the case of a serious medical condition, a student may not be capable of full-time enrollment. To comply with USCIS regulations, a student's medical condition must be substantiated by a licensed medical doctor or licensed clinical psychologist before an International Student Advisor can approve a reduced course load. The student must also demonstrate to the International Student Advisor that he or she is seeking treatment for the condition. Please complete the form below and return it to the International Students Office as soon as you know that you require medical leave, and cannot be done for more than three semester.

**Note:** Approval must be renewed each term if the condition persists beyond one academic term.

### PART I (to be completed by student)

Last Name (Family) \_\_\_\_\_ First Name (Given) \_\_\_\_\_

NDNU ID # \_\_\_\_\_ Phone # \_\_\_\_\_ Email \_\_\_\_\_

\_\_\_\_\_ Current Address \_\_\_\_\_

- You are required to report your address to SEVIS to maintain your immigration status.

**Degree Level (Circle)** Bachelor's      Master      PhD      Credentials      Major \_\_\_\_\_

**Term for which this form applies (Circle)** Fall      Spring      Summer      20\_\_\_\_

I (name of student) \_\_\_\_\_ authorize Dr. \_\_\_\_\_ to release medical information which pertains to my ability to enroll full-time to the International student's office at NDNU.

*\*Sponsor student only:* I understand that I must obtain approval from my sponsor **prior** to reducing my course load and any financial or other sponsorship consequences are my responsibility. Under the terms of our agreement with sponsors, NDNU is required to provide enrollment information to sponsors.

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Part II (to be completed by treating licensed medical doctor or licensed psychologist):

Your signature below certifies that this student has sought treatment for a condition which impedes his/her ability to enroll full-time. **Please note that a request of zero credits is permitted only in extreme circumstances, as it could affect student's ability to maintain health insurance and continue treatment.**

A letter from the medical doctor or licensed psychologist can replace this section.

Date (s) seen regarding this condition: \_\_\_\_\_

The student's condition warrants: (Check one)       Part-time enrollment       Withdrawal from the term (zero credit)

Comments: \_\_\_\_\_

\_\_\_\_\_  
**Signature of M.D., D.O. or Licensed Psychologist\***

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Business phone**

\_\_\_\_\_  
**Name of clinic/hospital where employed**

\*Federal law requires that only a licensed medical doctor or licensed psychologist substantiate a student's medical condition.