F-1 Extension of Status: Confirmation of Compelling Medical Reason

This form is required for the first/initial request of an extension of F-1 status due to a compelling medical reason.

- Future extensions of stay based on delays for medical reasons will require additional medical documentation.

To request an F-1 program extension for a compelling medical reason, students in F-1 status must submit formal documentation of the medical reason. Students requesting their first/initial extension based on a compelling medical reason can opt to have this form completed by a:

- U.S.-licensed Medical Doctor (MD);
- U.S.-licensed Doctor of Osteopathy (DO);
- U.S.- licensed Psychiatrist;
- U.S.-licensed Clinical Psychologist (CP); or
- U.S.-licensed Psychologist.

This completed form must be uploaded in the *Extension of I-20/F-1 Status* e-form (available in the MyISSS portal).

Student Information

Prior to submitting this form to the medical provider, complete this Student Information section.

Last Name: _____ First Name: _____

CU ID: _____

Enter the semester (e.g., Fall, Spring, Summer) and year in which you plan to graduate if granted an F-1 program extension:

Semester: _____ Year: _____

Attestation

☐ I affirm that the information I provided on this form is true and accurate.

☐ I affirm that this is my first/initial F-1 I-20 program extension request.

☐ I affirm that in the case I need an additional/subsequent F-1 program extension for compelling medical reasons, I will work with my medical provider to obtain additional medical documentation required for subsequent extension requests based on compelling medical reasons.

☐ I understand that after this form is completed by my medical provider, I must upload this form in the *Extension of I-20/F-1 Status* e-form (available in the MyISSS portal).

Signature: _____ Date:_____

Medical Provider/Treating Clinician

This section must be completed by the student's medical provider or treating clinician (if applicable).

Attestation

☐ I affirm the academic delays the student has experienced are caused by compelling medical reasons.

***If Applicable*: Treating Clinician (Not a U.S. Licensed MD, DO, CP, Psychologist, or Psychiatrist)**

☐ I affirm that the information provided on this form is true and accurate.

Signature of Treating Clinician: _____ Date: _____
Digital or ink signature

Name: _____ Title: _____

Name of Practice: _____

Phone: _____ Email: _____

Address of Practice:

_____
Street Address Suite/Unit City State Zip Code

***Required for F-1 Program Extension*: U.S. Licensed MD, DO, Clinical Psychologist, Psychologist or Psychiatrist**

☐ I affirm that the information provided on this form is true and accurate.

Signature of Medical Provider: _____ Date: _____
Digital or ink signature

Name: _____ License Number: _____

U.S. State(s) in which Licensed to Practice: _____

I confirm that I am a:

☐ U.S. Licensed Medical Doctor (MD)
☐ U.S. Doctor of Osteopathy (DO)
☐ U.S. Licensed Psychologist
☐ U.S. Licensed Clinical Psychologist (CP)
☐ U.S. Licensed Psychiatrist

Name of Practice: _____

Phone: _____ Email: _____

Address of Practice:

_____
Street Address Suite/Unit City State Zip Code