International Student & Scholar Services
UNIVERSITY OF COLORADO **BOULDER**

Medical Reduced Course Load Recommendation Form

ISSS may authorize a reduced course load (RCL) or, if necessary, no course load, due to a student's temporary illness or medical condition for a period not to exceed an aggregate of 12 months per academic degree level. To be authorized for a medical RCL, this form must be completed by a:

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

Students requesting a medical reduced course load are required to upload this completed form in the *Medical Reduced Course Load (RCL) Request* e-form (available in the MyISSS portal).

Student Information

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

Full Name: ____ CU ID: _____________
First and Last Name

Enter the semester and year (e.g., Fall 2024) for which you are requesting the Medical Reduced Course Load authorization:

☐ Fall 20____
Year

☐ Spring 20____
Year

☐ Summer 20____ (summer registration only required in the first and final semesters)
Year

Attestation

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

☐ I affirm that I have not been authorized for an aggregate of 12 months or more of medical reduced course loads at this degree level.

☐ I affirm that I understand that I cannot drop any courses until ISSS authorizes a medical reduced course load and provides me with a new I-20 with a medical reduced course load authorization included on it.

☐ I understand that after this form is completed by my medical provider, I must submit this form to ISSS by completing the *Medical Reduced Course Load (RCL) Request* e-form (available in the MyISSS portal).

Signature: _________________________________ Date:____________________
Digital or ink signature

Medical Provider/Treating Clinician

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

Based on my diagnosis, I recommend a:

☐ Partial Reduced Course Load (at least one credit hour)

☐ Full Reduced Course Load (no enrollment for the semester)

Semester and Year for this Recommendation (only one semester can be recommended at a time)

☐ Fall 20___ ☐ Spring 20___ ☐ Summer 20___

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

☐ 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 Medical Reduced Course Load*: U.S. Licensed MD, DO, Clinical Psychologist, or Psychologist**

☐ 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)

Name of Practice: ____

Phone:__________________________ Email: ____________________________

Address of Practice:

____

Street Address Suite/Unit City State Zip Code