REQUEST FOR APPROVAL TO TAKE A REDUCED COURSE LOAD (RCL) DUE TO MEDICAL CONDITION

To apply for approval to take a reduced course load (less than 12 units for undergraduates/8 units for graduates) due to medical condition, permission from OIP MUST be obtained:

- If the student is not planning to enroll full-time due to medical condition: permission must be obtained before the student registers, or within 2 weeks of the semester start at SF State
- If the student is enrolled full-time and medical condition occurs during the semester: contact an advisor at OIP immediately

An F-1 student who registers for less than a full course of study without the prior approval of OIP may result in the termination of his/her SEVIS record for which there may be severe consequences to his/her legal status in the U.S.

In order for the OIP to approve this request, students must request a licensed medical doctor, doctor of osteopathy, or licensed clinical psychologist to complete the 2nd page of this form, or attach an original letter from the doctor (on the doctor’s original letterhead stationary) substantiating the student’s illness or medical condition (this means a brief but detailed description of student’s medical condition/illness), The doctor’s letter must also recommend that the student enroll in either 0 units or in a part-time course of study for this semester.

A reduced course load or withdrawal from SF State due to a medical condition cannot exceed a total of more than 12 months (Summer session is not included). A separate request form must be completed and approved each semester, if more than one semester of reduced course load or withdrawal is needed.

If the request is approved, student must resume a full course of study in the next available Fall/Spring Semester in order to maintain legal student status, unless another RCL is approved.

TO BE COMPLETED BY THE STUDENT

<table>
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<tr>
<th>Semester &amp; Year for RCL:</th>
<th>Fall 20________</th>
<th>Spring 20________</th>
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Name: __________________||(first/given)  __________________||(last/family) 
SF State Student ID: 9 __________________| SEVIS ID: N __________________|
E-Mail Address: __________________@mail.sfsu.edu | Phone: ______ - __________________|
Major Field of Study: __________________ | I-20 Expiration Date: ______ / ______ / ______ |
I plan to enroll in and complete ______ units for the above indicated semester at SF State.
Have you ever been approved for a RCL due to medical conditions at another U.S. school?  Yes  No
I have the following medical documentation:

- [ ] Page 2 of this form
- [ ] Doctor’s letter

Signature: __________________| Date: ______ / ______ / ______
TO BE COMPLETED BY MEDICAL DOCTOR, DOCTOR OF OSTEOPATHY, OR LICENSED CLINICAL PSYCHOLOGIST

Semester of recommended reduced course enrollment:  Fall 20____  Spring 20____

Please substantiate the student’s illness or medical condition:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Does the medical condition prevent the student from enrolling full time?  ☐ No  ☐ Yes

If yes, how many units (0-12) do you recommend the student take in the semester?  _______ Units

“I recommend a reduced academic course load due to the student’s current medical condition.”

Signature of M.D./D.O./Licensed Clinical Psychologist: ________________________________

Print Name and Title: ________________________________________________________________

Name of the Hospital/Clinic: __________________________________________________________

Mailing Address: _____________________________________________________________

Phone: ____________________________  E-mail: ________________________________

Date: ________/_______/__________

TO BE COMPLETED BY OIP

Approved  Denied  OIP Advisor’s Initials: _________  Date Student Notified: ________

Date Entered into SEVIS: ________

PLEASE RETURN THIS FORM TO AN OIP ADVISOR DURING DROP-IN HOURS