



# THE UNIVERSITY OF TEXAS AT DALLAS

International Student Services  
800 W. Campbell Rd., SSB34, Richardson, Texas 75080-3021  
(972) 883-4189 ISSOJ1@utdallas.edu

## UT Dallas J-1 Reduced Course Load (RCL) Request Due to Medical Reasons

Student Name: \_\_\_\_\_ UTD ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **A. Read the following information.**

- Submit this completed form to the ISSO **prior** to dropping classes.
- If approved, you will be authorized for reduced enrollment for one semester.
- Once you have received the authorization you are eligible to drop classes without affecting your immigration status.
- Repeat the process for each affected semester.

### **B. Student Certification (handwritten signature required).**

I verify that the information on this form is true to the best of my knowledge. I am aware that I may need to consult with other campus offices to ensure that reducing enrollment will not affect my status, such as: Residential Life (if residing on campus), academic department, Bursar's Office, or Education Abroad ([EducationAbroad@utdallas.edu](mailto:EducationAbroad@utdallas.edu)).

Academic Term/Year for Reduced Enrollment (Ex. Spring 2016) \_\_\_\_\_

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

### **C. Medical Certification. To be completed by U.S. licensed medical doctor, doctor of osteopathy or clinical psychologist.**

The above-named student is in the U.S. on a J-1 visa. J-1 students must be full-time enrolled every fall and spring semester unless officially authorized. Your authorization will be kept on file at UT Dallas and can be audited by the U.S. Department of State and Department of Homeland Security. If you have questions regarding this form or visa requirement, contact the U.T. Dallas ISSO at 972-883-4189.

Doctor Name: \_\_\_\_\_

Physical Office Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Prescribed Medical Treatment: \_\_\_\_\_

\_\_\_\_\_

How many credit hours do you recommend the student maintain this semester?  9  6  3  0

I verify that I hold the following title:

Licensed medical doctor License Number: \_\_\_\_\_

Doctor of Osteopathy

Licensed Clinical Psychologist License Number: \_\_\_\_\_

I recommend that the above student be given permission to register for less than full time is based on the above reason.

Doctor/Psychologist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **D. Submit your RCL Request to the ISSO Office prior to dropping below full time enrollment.**

- **In person:** Submit to the ISSO during office hours. Monday - Thursday, 8 a.m. to 6 p.m. Friday, 8 a.m. to 5 p.m.
- **By e-mail** (additional paper copies are not required): Submit to [ISSOJ1@utdallas.edu](mailto:ISSOJ1@utdallas.edu). Verify that the total size of attachments in one e-mail is not larger than 5MB. Do not send files in compressed formats, such as .rar or .zip. Instead, use a PDF, JPEG or DOC format.

### **E. International Student Advisor Certification (handwritten signature required)**

I certify that at the time of the signature, the student above is authorized for reducing enrollment due to medical reason.

Advisor/ARO Signature: \_\_\_\_\_ Date: \_\_\_\_\_