CERTIFICATION FOR MEDICAL REDUCED COURSE LOAD FOR STUDENTS IN THE F-1 AND J-1 NONIMMIGRANT CATEGORIES

For Student: Please fill out the top half of this form and then provide this form to your medical provider. The provider should fill out and sign the bottom half of this form and then return it to you to upload into the iGlobal portal. You will be notified when International Advising decides on your request**. Do not drop below full-time until you are notified of approval.** For more information about UNO Medical Withdrawals, see https://www.unomaha.edu/campus-policies/medical-withdrawals.php. If you are withdrawing from class mid-semester, you must email medicalwithdrawals@unomaha.edu.

Name ________________NU ID________________Session/Semester and Year______

For Medical Provider: The student above is requesting to drop below a full-time course load. Full-time is as follows: 9 credits per semester for graduate level, 12 credits per semester for undergraduate level, and 18 hours per week for our Intensive Language program (ILUNO)Pursuant to 8 CFR 214.2(f)(6)(iii)(B), the UNO International Programs Office requires that a licensed **medical doctor, psychiatrist, doctor of osteopathy, licensed psychologist, or clinical psychologist** certify that the student should drop below a full-time course load because of a temporary illness or medical condition before the reduced course load is authorized. Please fill out the information below and then return this form to the student so that they may file the request with our office.
If you have any questions regarding this form, please contact International Student Advising at unointladvising@unomaha.edu.

Medical Reduced Course Load Recommendation: "I certify that this student is compelled by illness or other medical condition to reduce their course of study to ___ credit hours" (for undergraduate or graduate students) or ___ hours of study per week for students studying in the Intensive Language program (ILUNO).

Name of treating MD, DO, or licensed psychologist_____________________________

Clinic Name, Address, and Phone Number____________________________________

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State License Number, if applicable _______________________Date ______________

Signature of treating MD, DO, or licensed psychologist______________________

University of Nebraska Omaha

INTERNATIONAL PROGRAMS
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