

# MEDICAL VERIFICATION FORM

Recommendation for student to drop below a full course of study



**SEATTLE CENTRAL COLLEGE**

*International Education Programs (IEP)*

Part 1: To be completed by STUDENT		
Student ID Number	SEVIS Number <b>N</b>	
Last (Family) Name	First Name	Middle Name(s)
Phone Number	Email Address	
Current Address		
STUDENT SIGNATURE:		DATE:

Part 2: To be completed only by a Medical Doctor, Doctor of Osteopathy, or Licensed Clinical Psychologist
<p>Federal law requires that international students, as non-immigrant visa holders, take a full course load during their studies in the U.S. This means 12 course hours for undergraduates. Students may be authorized to enroll in less than full-time coursework or, if necessary, in no classes at all due to a temporary illness or medical condition.</p> <p>In accordance with United States Federal Register 8 CFR 214.2 (f)(6)(iii)(B), <u>only a U.S. licensed medical doctor, doctor of osteopathy, or licensed clinical psychologist may substantiate the illness or medical condition.</u></p> <p style="text-align: center;"><b><i>Please return this form to the student or send directly via email or fax to the International Education Programs office at Seattle Central College.</i></b></p> <p style="text-align: center;">FAX: 206-934-3868 ♦ PH: 206-934-3893 ♦ Email: SeattleCentral.Intl@seattlecolleges.edu</p>

<p><b>I recommend (please check one):</b></p> <p><input type="checkbox"/> Reduced academic course load (part-time study)</p> <p><input type="checkbox"/> Withdrawal from all courses / no enrollment</p> <p><input type="checkbox"/> Student should be able to handle full course load</p> <p><b>Comments/reason:</b></p>	<p><b>Effective for the following quarter(s):</b></p> <p><input type="checkbox"/> Fall (September-December)</p> <p><input type="checkbox"/> Winter (January-March)</p> <p><input type="checkbox"/> Spring (April-June)</p> <p><input type="checkbox"/> Summer (June-August)</p>
<p><b>To the best of my knowledge, this patient should be able to resume full-time study as required for F-1 student immigration status by _____, 20____.</b></p>	

Name (please print)	Credential/Title
Signature	Date
Hospital/Clinic/Facility Name & Address	
Phone Number	Email Address

For IEP Advisor / Office Use Only		
<input type="checkbox"/> DB: Enrl tab & Immig note <input type="checkbox"/> SEVIS/fsa	<input type="checkbox"/> email student <input type="checkbox"/> WD Course(s)	Notes By (init.)