

Health Care Provider's Letterhead

(Including name of facility, address)

Date:

Student Name:

Date of Birth:

Ms. XX is a patient currently under my care, who has a medical condition which prevents her from pursuing full-time studies for the Fall 2016 semester. As her physician, it is my recommendation she be allowed to register for only 3 semester hours during the semester. It is expected that she will be able to resume full-time studies during the Spring 2017 semester.

Health Provider's Typed Name and Degree (can only come from MD, DO, or clinical psychologist as per federal student visa regulations):

Health Provider's Signature:

Health Provider's Email:

[**Note to health care provider:** This letter is to be used by your patient to satisfy federal regulations for those on a student visa who seek authorization to drop below full-time enrollment. The information and format above provides all of the details required by federal regulations. In order to ensure a letter is not a forgery, International Student and Scholar Services may contact you to verify that you created the letter submitted to our office. Thank you for your time on behalf of your patient.]