Physician or Counselor's Recommendation for Reduced Course Load

Student Name: _____ Student ID# _____
family name given name

Student's Date of Birth: _____ Alternative Email Address: _____

Date: _____ Semester: _____

1) Physician or Counselor: As the physician or counselor of the student named above, please place an "X" beside the statement below that best fits your recommendation regarding the student's involvement in taking coursework for the indicated semester. Please also attach a letter according to the detailed instructions in section 2 below.

Following my consultation with the student on _____:
Date

a. ____ I believe that taking fewer classes would be beneficial for this student's condition.

b. ____ I believe that this student should take only ___ credit hours for the semester in light of the student's condition.

c. ____ I believe that this student should not enroll in any classes in light of the student's condition. (See *** below.)

d. ____ Other: Please explain in a letter according to the detailed instructions in section 2 below.

Signature of Physician or Counselor: _____

Printed name of Physician or Counselor: _____

Office phone: _____ Office email: _____

Office Address of Physician or Counselor: _____

_____

2) Physician or Counselor: Please attach a brief letter on your office letterhead addressing the student's condition and your recommendations. Please include information you may have provided for the student with regard to how you recommend they use the additional time they will have that would normally be spent in class and studying during their time of recovery. Please attach your letter to this form and forward to the International Office address at the bottom of the page to my attention as follows: Confidential—Attention: Dr. Bob Seese.

*** If option "c" is chosen above, the student will be still charged the standard $60 for the International Operations fee for the semester they are not enrolled. The student must bring proof of medical insurance to the International Office, which meets Texas State's standards for medical insurance for international students. The policy must have been approved as having met these standards by the Student Health Center.

Student Signature: _____ **Date:** _____

Texas State University-San Marcos, International Office-Hill House, 601 University Dr., San Marcos, TX 78666-4616