



International and Immigrant Student Services



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Reduced Course Load (RCL) Request Form – Medical Condition

The DSO may authorize a reduced course load (or, if necessary, no course load) due to a student's temporary illness or medical condition for a period of time not to exceed an aggregate of 12 months while the student is pursuing a course of study at a particular program level.

PART I: TO BE COMPLETED BY STUDENT

Last/Family Name First Name

Street address (number and name of street) City State ZIP Code

JCCC ID #: SEVIS ID#: Date of Birth: MM/DD/YYYY

Phone#: JCCC email address:

I am requesting RCL for medical reason for: Fall or Spring or Summer Year:

- I understand that if I remain in any courses while on medical RCL, they must be face-to-face courses.
I understand I need to request a letter for health insurance purposes and enroll full-time the next available semester.

I hereby give permission for the information below to be released to Johnson County Community College.

Signature Date

PART II: TO BE COMPLETED BY STUDENT'S MEDICAL PROVIDER

The student named above has applied for reduced course load due to student's temporary illness or medical condition. In addition to this form, for insurance purposes, the student must provide a supporting letter from a licensed medical doctor, psychiatrist, doctor of osteopathy, licensed psychologist, or clinical psychologist. The information provided is fully protected by FERPA (Family Educational Rights and Privacy Act).

Please complete the information below:

My office address is (include city, state, and ZIP code):

I hereby certify that the student has, in person, in my office, executed a medical release, allowing me to provide this information to you.

I hereby certify that I fully examined the student named above, in person, in my office, at the address indicated above, on (mm/dd/yyyy).

I hereby certify that the student is suffering from.

For the Fall 20 or Spring 20 or Summer 20 semester, I recommend the student:

- take no more than credit hours of classes OR totally withdraw from all classes (i.e., no enrollment)

Signee please note: the information you provide will be utilized in connection with an application for a federal immigration benefit, and is subject to the perjury provisions of 18 USC 1001.

Medical Provider's Name:

Provider's Signature:

Medical Area of Specialty/Licensure: Date:

Telephone: Email Address:

PART II: TO BE COMPLETED BY IISS/DSO

The student named above has has not previously been approved medical RCL. Duration:

RCL for medical reason has has not been approved for Semester/year

SEVIS updated: BANNER updated: DSO: Printed Name

MM/DD/YYYY MM/DD/YYYY