

Academic Advisor Certification J-1 Classification



The U.S. Department of State, which administers the Exchange Visitor (J-1 visa) program, requires all international students holding the J-1 visa classification to be enrolled in a "full course of study" in order to maintain lawful status in the country. "A full course of study" consists of:

- (a) for graduate students: at least 9 hours per semester.
- (b) for undergraduate students: at least 12 hours per semester.

There are a few very specific situations which justify enrollment in fewer hours than the number set forth above. The academic justifications are set forth below. The medical justification is on the reverse side of this form.

Please advise as to whether

Name

Social Security Number

meets any of the academic exceptions to the "full course study" requirements by checking an appropriate response below:

- 1. The student needs fewer hours to complete his/her program during the current semester.
- 2. The student has completed all coursework for his/her degree and is studying full-time for comprehensive examinations in accordance with the regulations of the Graduate College.
- 3. The student is working full-time on his/her thesis or dissertation requirements in accordance with the regulations of the Graduate College.
- 4. The student is compelled to pursue less than a full course of study "due to an academic reason," which is _____

Expected Degree

Academic Advisor's Name (printed)

Date

Expected Date of Completion

Academic Advisor's e-mail

Phone

Department

Academic Advisor's Signature

_____, 20____
Semester Applicable

Thank you. Please return to:
International Affairs
420 University Terrace 0682
Tel: 472-5358

Acceptable **only** if returned in **sealed**
department envelope.

Medical Certification for Less- Than-Full Time Student Status

F-1 and J-1 Visa Classification

_____ is compelled by illness or other medical
(Name) (Social Security or ID Number)
condition to interrupt or reduce the course of study for the _____ 20 ____ semester.

_____, M.D. _____
Treating Physician (Print Name) Signature

_____, D.O. _____
Treating Doctor of Osteopathy (Print Name) Signature

_____, Lic # _____
Treating Licensed Clinical Psychologist
(Print Name and License Number) Signature

Clinic _____

Address _____

Phone _____

Acceptable only if returned in sealed office envelope.

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