Reduced Course Load Application
To Be Completed by Academic Advisor or Doctor Only

Name: __________________________ W#: __________ Semester requested: __________
Weber email: _____________________ Degree program: _______________________

Please choose one of the following:

☐ Academic Difficulties: Initial difficulty with the English language or reading
requirements (FIRST TERM ONLY), unfamiliarity with American teaching methods
(FIRST TERM ONLY), or improper course placement due to an advising error.

☐ Medical Conditions: Must be based on a medical condition diagnosed and
documented by a licensed medical doctor, doctor of osteopathy, or licensed clinical
psychologist. Documentation must be specific and must accompany this form. The
physician or psychologist must recommend either part time or no enrollment, and
must indicate the term for which the reduced course load is applicable. A reduced
course load for medical reasons may be recommended for more than one term, but
cannot exceed 12-months. The student must reapply for a reduced course load each
quarter/semester.

☐ Completion of Course of Study: The student has verified through an official degree
check that he/she needs _____ hours (FILL IN NUMBER) to complete the degree
program. The student will be enrolled for these hours this semester and will be able to
complete the program no later than the end of this semester.

☐ Concurrent Enrollment: The student is taking _____ credit hours at another
approved institution. These courses will fulfill Weber State University degree
requirements, and concurrent enrollment between both schools will equal a full
course of study. More than half of the units must be at Weber State University. The
student has prior approval from their department and the Registrar's Office verifying
the courses taken at another institution will be counted toward the degree program.

☐ Graduate Assistantship: A graduate student with approved assistantship of 15 hours
or more per week (ATTACH SIGNED AGREEMENT AND CONTRACT)

__________________________________________________________________________
Academic Advisor or Doctor Name (print)                                             Signature

____________________________________________________________________________
Title                                                                                     Date

----------------------------------------------------------------------------------------------------------------- To Be Completed by ISSC -------------------------------------------------------------------
Date received: __________     By: __________________________________________
Date processed: __________     By: __________________________________________