



**Medical Leave of Absence, Mental Health Care Provider Form**

*Instructions: This form is to be completed by the student's community mental health provider and be mailed to: Student Health and Counseling, Attention: Amy Gonzalez, 1 College Circle, Geneseo NY, 14454 or faxed to 585-245-5071.*

Student name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Provider name: \_\_\_\_\_ License #: \_\_\_\_\_

Provider licensed as: \_\_\_\_\_ State of licensure: \_\_\_\_\_

Dates of treatment (first session and most recent): \_\_\_\_\_

Treatment modalities (individual, group, IOP, inpatient, etc.): \_\_\_\_\_

Treatment program name (if applicable): \_\_\_\_\_

Initial DSM-V diagnoses: \_\_\_\_\_

Current DSM-V diagnoses: \_\_\_\_\_

Other relevant clinical issues:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Clinician signature: \_\_\_\_\_ Date: \_\_\_\_\_

2/2025