



**Return from Medical Leave of Absence, Health Care Provider Form**

*Instructions: This form is to be completed by the student's community health provider and be mailed to: Student Health and Counseling, Attention: Amy Gonzalez, 1 College Circle, Geneseo NY, 14454 or faxed to 585-245-5744.*

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

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

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

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

Treatment details (e.g., surgery, hospitalizations, medications, rehabilitation):

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

ICD-10 diagnoses: \_\_\_\_\_

Other relevant clinical issues: \_\_\_\_\_

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

**Please provide your professional judgment in response to the following questions:**

Has there been a substantial amelioration of the student's original medical/psychological condition?

\_\_\_yes \_\_\_no

If yes, please check all of the following that you have observed a marked reduction of in this student:

- |                               |   |
|-------------------------------|---|
| _____ number of symptoms      | _____ functional impairment               |
| _____ severity of symptoms    | _____ subjective level of client distress |
| _____ persistence of symptoms |   |

***Please use the space below to let us know, in your professional judgement, given the academic rigor and physical challenges associated with the college environment, if, in your professional judgement, this student is healthy enough continue pursuing their education, in this setting, at the current time. Please include any special considerations or treatment recommendations this student may benefit from once returning to campus:***

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