NOTE: This form is to be completed by the student’s licensed mental health service provider and mailed by the provider directly to the St. John’s University Health Related Leave Review Committee at the address indicated above.

Clinician Name _______________________________  Student Name ____________________________________

Licensed as a_________________________________  First session date _________________________________

License # ____________________________________  Most recent session date __________________________

State of Licensure ____________________________  Total # treatment sessions _________________________

Initial DSM Axis I diagnosis____________________  GAF score at first session _________________________

______________________________________________________________________________________________

Current DSM Axis I diagnosis____________________  Current GAF score ______________________________

______________________________________________________________________________________________

Please provide your professional judgment in response to the following questions regarding the student named above.

___ Yes  ___ No  Has there been a substantial amelioration of the student’s original medical/mental health condition?

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

  ___ Number of symptoms
  ___ Severity of symptoms
  ___ Persistence of symptoms
  ___ Functional impairment
  ___ Subjective level of client distress

___ Yes  ___ No  Once achieved, has the student’s substantially improved condition been maintained at a stable level for at least three consecutive months?
Has there been a substantial reduction of any of the following safety-related behaviors the student may have been engaging in?

___ Yes ___ No ___ N/A  Suicidal behaviors
___ Yes ___ No ___ N/A  Self-injurious behaviors
___ Yes ___ No ___ N/A  Substance abuse behaviors
___ Yes ___ No ___ N/A  Food binging
___ Yes ___ No ___ N/A  Food purging or any other potentially harmful compensatory behaviors that may be utilized for weight management (e.g., use of laxatives, excessive exercise, etc.)
___ Yes ___ No ___ N/A  Failure to maintain minimum of 90 percent Ideal Body Weight for height
___ Yes ___ No ___ N/A  Threats of physical harm to others or damage to property
___ Yes ___ No ___ N/A  Other:  ____________________________________________________________
___ Yes ___ No  Once achieved, has the substantial reduction in safety-related behaviors been maintained stably for at least three consecutive months?

__________________________________________________________________________

Clinician Signature Date

Please provide written documentation, on letterhead, that expands on your responses to the questions above. In your letter, please indicate dates of evaluation and/or treatment, a clear recommendation that the student cannot continue his/her academic program because of his/her mental health condition(s), and an estimate regarding the time period for a Health Related Leave of Absence. Thank you for your time and attention to this important matter.