NOTE: This form is to be completed by the student’s licensed medical 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 ___________________________

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?

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 medical 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.