Provider Form-Request for Health Related Leave of Absence (HRLOA)

Section 1: To Be Completed by the Student		
Student's Name:	_____	
Student's Address:	_____	
	City/Town: _____	Zip Code: _____
Student's Telephone number:	(H) _____	(C) _____
Student's email address:	_____	
X Number:	_____	

- I am requesting a Health Related Leave of Absence
- I understand that the Health Related Leave of Absence Committee Office may share this information with other St. John's University officials in connection with my application for a Health Related Leave of Absence (HRLOA).

Student Signature: _____ Date:_____

Section 2: To Be Completed by Health Care Provider

This is to be completed by the student's treating physician, licensed mental health provider, or other licensed healthcare provider. The provider must be an impartial diagnostician who does not have an immediate familial relationship with the student.

Providers: The above-named student has requested a Health Related Leave of Absence from St. John's University. Please complete each item on this form and return it to St. John's University at 718-990-2609 (Fax) or healthrelatedleave@stjohns.edu.

Health Care Provider's Name:	_____	__MD __DO __PhD __MA __LPC __LCSW Other: _____	
Licensed as a:	_____	License # _____	State of Licensure: _____
Health Care Provider's Address:	_____		
	City/Town: _____	Zip Code: _____	
Health Care Provider's Telephone number:	(O) _____	(F) _____	
Health Care Provider's email address:	_____		

Section 2: To Be Completed by Health Care Provider (continued)	
REASON FOR REQUEST FOR HEALTH RELATED LEAVE OF ABSENCE	
Your assessment and treatment of the student is for:	_____Medical reasons _____Psychological/Mental Health reasons _____Other
Please briefly describe the specific issues or concerns that caused the student to seek a medical intervention or mental health treatment/assessment with you: _____ _____	
When did you first assess or treat this student for this concern?	Date: _____/_____/____
Since your initial assessment of the student how many follow-up appointments have you had with the student?	# of appointments: _____
Date of most recent appointment with the student:	Date: _____/_____/____
Please explain the impairments that presently inhibit the student from functioning successfully and safely at St. John's University. _____ _____	
Please describe your treatment recommendations for the student: _____ _____	
Are you scheduled to follow-up with the student regarding the above stated concern:	☐ Yes ☐No
• If Yes, please indicate the date of your next appointment with the student, Date: _____/_____/____	
• In no, please describe your rationale for not scheduling a follow-up appointment: _____ _____	
Any additional information you think would be helpful for the University to know: _____ _____	
Your Recommendation: I recommend that the above named student be granted a Health Related Leave of Absence ☐ Yes ☐No	
Signature of provider: _____ Date:_____	