Provider Form- Request to RETURN from 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 return from 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 Return from 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 been on a Health Related Leave of Absence from St. John's University, and is wishing to return. 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 TO RETURN FROM A HEALTH RELATED LEAVE OF ABSENCE	
Your assessment and treatment of the student is for:	_____Medical reasons _____Psychological/Mental Health reasons _____Other
Did you provide the student's initial assessment/treatment that was used to support their application for HRLOA	___No ___Yes

Please describe the student's initial presenting symptoms:

_____
_____

Please describe the student's current level of functioning:

_____
_____

Please identify the student's diagnosis:

_____
_____

Please provide an opinion regarding the students readiness to successfully and safely resume academic and university life at St. John's University:

_____
_____

Please identify any accommodations the student will require successfully and safely resume academic and university life at St. John's University:

_____
_____

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 describe your treatment recommendations, if any, for the student upon return to St. John's University:

_____
_____

Will you continue to provide services to this student while at St. John's University? ☐ Yes ☐No

If Yes, please indicate the date of your next appointment with the student, Date: _____/_____/____

If No, to whom will the student's care be transferred?

Health Care Provider's Name:	
Licensed as a:	
Health Care Provider's Address:	

Health Care Provider's Telephone number:	
Health Care Provider's email address:	

Based on your current evaluation, do you believe that the student is now able to meet the expectations of a full-time student? □ Yes □ No
Comments:_____
_____

Do you have any reservations regarding the student's full time enrollment in a high intensity academic environment? □ No Reservations □ Reservations (please explain)
Comments:_____
_____

In your professional opinion do you have any reason to believe that the student's is a danger to self or others (including being contagious with an infectious disease)? □ No □ Yes (please explain)
Comments:_____
_____

Signature of provider: _____ Date:_____