

# **K** KALAMAZOO COLLEGE

## Medical Leave of Absence Health Care Provider Report (3 pages)

### Instructions for the Student:

Complete Part 1 of this form.

Deliver the form to your Healthcare Provider as soon as possible. Be sure that your Health Care Provider has the form in time to complete it and send it to campus so that it arrives no less than 30 days before the beginning of the quarter in which you seek reinstatement.

Note: The Healthcare Provider who completes this form must be your treating licensed mental health provider, or other licensed healthcare provider who is familiar with you, the reason(s) for your medical leave of absence, and your treatment during that leave of absence. The provider may not be your relative.

### Instructions for the Healthcare Provider:

In responding to each question, we want to be clear that the College seeks only medical information that is related to the student's medical leave of absence and the student's request to be reinstated.

Complete Part 2 of this form.

Sign the form. An unsigned form will not be accepted.

Return the form directly to Dana Jansma, Associate Dean of Students, as a scanned email attachment (dana.jansma@kzoo.edu) or via fax (269-337-7404). **The form is due 30 days before the start of the quarter in which the student seeks reinstatement** (Aug. 16 for fall 2019; Dec. 6 for winter 2020; Feb. 28 for spring 2020).

Note: The College must receive this form directly from the Healthcare Provider. Any form that is received any other way will be disregarded, possibly affecting the student's eligibility for reinstatement.

### Part 1: Student Information

Name: \_\_\_\_\_ Student ID# \_\_\_\_\_  
Last First

Mailing Address: \_\_\_\_\_  
Street City State Zip

Phone Number: \_\_\_\_\_ Email address: \_\_\_\_\_@kzoo.edu

Requested return to Kalamazoo College (circle one)      Fall      Winter      Spring      20\_\_

I certify that the information provided above is true and correct, that I have submitted Part 2 to my Healthcare Provider for them to complete and return to Kalamazoo College, and that I am not related to my Healthcare Provider.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**Part 2: Healthcare Provider Report**

Provider Name: \_\_\_\_\_  
Last First Middle Initial

License(s) Held and Issuing State: \_\_\_\_\_

What is your specialty? \_\_\_\_\_

Clinic or Hospital Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Phone Number: \_\_\_\_\_ Email address: \_\_\_\_\_

*Please include additional documentation if you wish to expand on your responses to the following questions and/or to record any other comments or observations regarding the student that will help Kalamazoo College evaluate whether the student meets the standards and requirements to be readmitted to the College and participate in its education programs. **Return this form to [dana.jansma@kzoo.edu](mailto:dana.jansma@kzoo.edu) or via fax at 269-337-7404.** Thank you.*

Have you treated the student for the condition related to their medical leave of absence?  Yes  No

If yes, when did you first treat the student for that condition? \_\_\_\_\_

When did you most recently treat the student for that condition? \_\_\_\_\_

How many times did you treat the student for that condition? \_\_\_\_\_

What is the clinical or medical diagnosis for that condition (if applicable)? \_\_\_\_\_

Please describe your treatment of the student for this diagnosis. Include the nature of your treatment, medications you prescribed or recommended (and dosages), and the student's response to the treatment:

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

Has the student's condition improved since you started treating them?  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In your professional judgment, can the student:

Manage a full course load?  Yes  No

Attend a lecture of at least two hours?  Yes  No

Concentrate on and grasp complex reading materials?  Yes  No

Spend hours studying?  Yes  No

Organize and write papers?  Yes  No

Balance academic demands with extracurricular activities?  Yes  No

Live and learn in a community with others?  Yes  No

Please explain your answers above: \_\_\_\_\_

\_\_\_\_\_

Please describe any activities or responsibilities the student maintained during their leave of absence that suggests that they are ready to return to the rigors of academia (*e.g.*, a job, volunteering, classes, etc.)?

\_\_\_\_\_

Does the student require additional treatment for their condition?  Yes  No

Will you continue to treat the student for their condition?  Yes  No

If the student returns to Kalamazoo College, will they have any medical restrictions?  Yes  No

If yes, please describe the restrictions: \_\_\_\_\_

\_\_\_\_\_

What support do you recommend the College have in place, realizing the limitations of an academic setting?

\_\_\_\_\_

Healthcare Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_