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 (email or fax) 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, Senior 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**.

> 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: _____

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 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 (modality, frequency, interventions, etc.).

_____

_____

Please describe the student's participation in treatment with regard to their level of engagement, motivation, and adherence to treatment goals.

_____

_____

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 if known (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: _____