



## **MEDICAL LEAVE OF ABSENCE (MLOA) REQUEST FORM**

### **SECTION I: To be completed by the student:**

Students requesting a medical leave of absence (MLOA) must have their treating physician or licensed healthcare provider submit this MLOA recommendation form (i.e., primary care provider, specialist, psychiatrist, therapist, etc.). This form must be completed in full and submitted to Student Care Coordination by emailing [MLOA@vanderbilt.edu](mailto:MLOA@vanderbilt.edu).

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Term for which you are requesting an MLOA: \_\_\_\_\_ / \_\_\_\_\_  
Term Year

### **SECTION II: To be completed by licensed treatment provider:**

The above-named student is seeking to take a medical leave of absence from Vanderbilt University and this information is needed in order to process that request. This student has been made aware that expectations during a medical leave of absence include continuous engagement in treatment until their provider determines the concerns that led to the leave of absence are adequately addressed and they can successfully return to the academic environment. It is expected students will participate in the appropriate level of care needed to address these concerns, as determined by a medical/mental health professional.

You should only complete this form if you are a medical/mental health professional that can make a determination regarding the appropriate level of care necessary or, in the case where that professional is unavailable to complete the form, that you have the knowledge and expertise to serve as a substitute.

Please complete the following information, sign, and return this report to Student Care Coordination using the contact information noted below. If necessary, attach additional documents to expand on your recommendations.



**Treatment Information**

Current Diagnosis(es) (if applicable): \_\_\_\_\_

Current Medications (if applicable):

<u>Medication</u>	<u>Date Started</u>	<u>Dosage/Frequency</u>	<u>Stable</u>
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Recommendations for continued medication management while on leave (if applicable):

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

Will you continue to provide services for this student while on leave?  Yes  No

If not, have follow-up services been arranged for when this student leaves campus?  Yes  No

Service/Provider Information: \_\_\_\_\_

**Recommendations for Treatment While on Leave:**

Please indicate which of the following options the student may benefit from during their medical leave of absence AND provide specific recommendations in the box which may include levels of care (I.e., intensive outpatient treatment, partial hospitalization, residential treatment, outpatient treatment, etc.), frequency, and duration of treatment that may help the student plan for their time away. Check all that may apply.

Specific Recommendations:
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- Psychological Counseling  
 Group  Individual
- Psychiatric Assessment
- Eating Disorder Support
- Drug and Alcohol Resources
- Medication Management
- Nutritional Support
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Specialty medical care (specify in the box above)
- Residential Care
- Other \_\_\_\_\_

Have you discussed these recommendations with the student?  Yes  No  
 Is student in agreement with these recommendations?  Yes  No

**TREATING PROVIDER INFORMATION/SIGNATURE**

*(We may contact you with a request for more detailed information)*

Provider name: \_\_\_\_\_

Credentials/Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Area of Medical/Mental Health Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please complete in full and return by mail or email to:

**Student Care Coordination**  
**ATTN: MLOA/Health Records**  
 PMB 351508, 2301 Vanderbilt Place  
 Nashville, TN 37235-1508  
 Email: [mloa@vanderbilt.edu](mailto:mloa@vanderbilt.edu)