

# MEDICAL LEAVE OF ABSENCE (MLOA) REQUEST FORM

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

Coordination by emailing MLOA@vanderbilt.edu.

Student Name:	Date of Birth:	/	_/
Term for which you are requesting an MLOA:/	r		
Acknowledgement: I understand that by requesting a Medical of and agree to complete the requirements outlined in the Stude Care Coordination website, which include but are not limited to a medical and/or mental health provider(s) until that provider(s) leave have been adequately addressed and I am able to success In accordance with policy, I further agree to seek the appropria medical/mental health provider below, unless otherwise stated licensed provider with access to the recommendation(s) and bat that any changes to the recommendations should be documented the clinical rationale for recommending a different course of tree.	ent Handbook and the o engaging in continuous) determines the conceptully return to the acacte level of care as reconfollowing further evalusis for it while on ML acacted in the return paperwent.	reference ous treatierns that demic encommended uation both OA. I unwork and	ted Student ment with t led to my nvironment. led by the by a nderstand speak to
Student's signature:	Date:		
Students requesting a medical leave of absence (MLOA) must healthcare provider submit this MLOA recommendation form psychiatrist, therapist, etc.). This form must be completed in fu	(i.e., primary care prov	vider, sp	ecialist,



## **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 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.

<b>Treatment Information</b>				
Current Diagnosis(es) (if applicable):				
Current Medications (if applicable):				
<u>Medication</u>	<u>Date Started</u>	Dosage/Frequency	<u>Stable</u>	
			☐ Yes ☐ No	
			□ Yes □ No	
			☐ Yes ☐ No	
			□ Yes □ No	
			□ Yes □ No	
Recommendations for continued medication ma	nagement while o	n leave (if applicable)	:	
Will you continue to provide services for this st				
If not, have follow-up services been arranged fo Service/Provider Information:	r when this studer	nt leaves campus? 🗆 Y	es □ No	

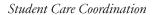




### **Recommendations for Treatment While on Leave:**

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:				
☐ 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? $\square$ Yes $\square$ No Is student in agreement with these recommendations? $\square$ Yes $\square$ 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:	Da	ate:	/	/	_

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: <u>mloa@vanderbilt.edu</u>