VANDERBILT UNIVERSITY

Student Care Coordination

MEDICAL LEAVE OF ABSENCE (MLOA) REQUEST FORM

SECTION I: <u>To be completed by the student</u>:

Student Name: _____ Date of Birth: ____/____/____

Term for which you are requesting an MLOA: _____/_____
Term Year

Acknowledgement: I understand that by requesting a Medical Leave of Absence (MLOA), I am aware of and agree to complete the requirements outlined in the Student Handbook and the referenced Student Care Coordination website, which include but are not limited to engaging in continuous treatment with a medical and/or mental health provider(s) until that provider(s) determines the concerns that led to my leave have been adequately addressed and I am able to successfully return to the academic environment. In accordance with policy, I further agree to seek the appropriate level of care as recommended by the medical/mental health provider below, unless otherwise stated following further evaluation by a licensed provider with access to the recommendation(s) and basis for it while on MLOA. I understand that any changes to the recommendations should be documented in the return paperwork and speak to the clinical rationale for recommending a different course of treatment than that previously provided.

Student's signature:_____ Date: _____

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.

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SECTION II: <u>To be completed by licensed treatment provider</u>:

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.

Treatment Information

Current Diagnosis(es) (if applicable): _____

Current Medications (if applicable):

Medication	Date Started	Dosage/Frequency	Stable
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ 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: _____

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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? ☐ Yes ☐ No
Is student in agreement with these recommendations? ☐ Yes ☐ No

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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