VANDERBILT UNIVERSITY
Student Affairs
Student Care Coordination

Deadlines for Return from MLOA	
Term:	**Must submit by:**
Fall	AUG 1
Spring	DEC 1
Summer	APRIL 1

MEDICAL LEAVE OF ABSENCE (MLOA)
TREATMENT PROVIDER REPORT

SECTION I: To be completed by the student:

Please ensure this form is completed by any and all providers who provided treatment during the MLOA dates listed below (i.e., primary care provider, specialist, psychiatrist, therapist, PHP, IOP, etc.). This form must be completed in full and submitted to Student Care Coordination by the deadline in the box above corresponding to the relevant term of return. Incomplete or late submissions may result in a delay in re-enrollment until the next term pending submission and approval of new documents.

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

Duration of Leave: ____/____/____ to ____/____/____

Term for which you are requesting to return from MLOA: _____/_____
Term Year

SECTION II: To be completed by licensed treatment provider:

The above-named student is seeking to return to Vanderbilt University after taking a medical leave of absence. 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 have participated 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 the medical/mental health professional that provided treatment to the student, 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 form based on the student's presentation and progress while under your care.

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 and the student's ability to function safely, stably, and successfully as a full-time student.

Treatment Information

Diagnosis(es) while under your care:

_____

_____

Date(s) of treatment:____/____/_____ to ____/____/_____

Total number of visits: _____

Was student compliant with treatment plan: ☐ Yes ☐ No (If no, please explain) _____

_____

Please provide details of treatment provided: _____

_____

_____

Medications while under your care (if applicable):

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

Recommendations for continued medication management (if applicable): _____

_____

_____

Will you continue to provide services for this student upon their return to campus? ☐ Yes ☐ No

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

Service/Provider Information: _____

Assessment of the Student:

Do you believe that this student is/was a danger to themselves while under your care? If you are actively treating this student, please provide your current assessment. ☐ Yes ☐ No

If yes, please explain: _____

Do you believe that this student is/was a danger to others while under your care? If you are actively treating this student, please provide your current assessment. ☐ Yes ☐ No

If yes, please explain: _____

What is/was your assessment of the status of the student's condition while under your care? If you are actively treating this student, please provide your current assessment. ☐ Good ☐ Fair ☐ Poor

While under your care, has/had this student demonstrated an ability to maintain a schedule and function productively in conjunction with or outside of the treatment program for at least 3 months? This could include holding a full or part-time job, pursuing regular volunteer work, taking a college-level course, or other productive activities. ☐ Yes ☐ No

If no, please explain: _____

_____

Do you have any reservations regarding this student's full-time enrollment in the rigorous academic environment at Vanderbilt University in the upcoming semester?

☐ No Reservations ☐ Reservations

Please explain: _____

_____

Recommendations for Support Services:

Please indicate which of the following options would be beneficial for the student when they return to campus and provide specific recommendations in the box below that will help the student succeed. Check all that may apply. *(Examples of specific recommendations may include: "Student would benefit from biweekly CBT sessions for continued treatment of anxiety;" "Student would benefit from weekly AA meetings and follow-up with psychiatry monthly for continued medication management.")*

Specific Recommendations:

☐ Psychological Counseling ☐ Group ☐ Individual

☐ Psychiatric Follow up

☐ Eating Disorder Support

☐ Drug and Alcohol Resources

☐ Primary or Specialty Medical Care

☐ Nutritional Support

☐ ADA Accommodations *(if recommended, additional documentation will be required)*

☐ On-Campus Housing

☐ Special Needs Housing

☐ Reduced Academic Course Load

☐ Medication Management

☐ Other _____

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

MEDICAL CARE 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