VANDERBILT UNIVERSITY®

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, etc.). This form must be completed in full and submitted to the Office of 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. Please complete the following information, sign, and return this report to the Office of 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 at this time.

Treatment Information

Current Diagnosis(es): _____

_____

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: _____

_____

_____

Current Medications:

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

Recommendations for continued medication management: _____

_____

_____

Will you continue to provide services for this student? □ 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 currently a danger to themselves? □ Yes □ No

If yes, please explain: _____

_____

Do you believe that this student is currently a danger to others? □ Yes □ No

If yes, please explain: _____

_____

What is your assessment of the current status of the student's condition? □Good □ Fair □ Poor

Has 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 in 30 days for continued management of Celexa.")*

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, fax or email to:

Office of Student Care Coordination
ATTN: MLOA/Health Records
PMB 351508, 2301 Vanderbilt Place
Nashville, TN 37235-1508
Fax: (615) 343-3702
Email: studentcare@vanderbilt.edu