

<u>Deadlines for Return from MLOA</u>	
<b>Term:</b>	<b>Must submit by:</b>
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:**

<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: \_\_\_\_\_

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

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:
---------------------------

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Psychological Counseling<br><input type="checkbox"/> Group <input type="checkbox"/> Individual | <input type="checkbox"/> Psychiatric Follow up             | <input type="checkbox"/> Eating Disorder Support |
| <input type="checkbox"/> Drug and Alcohol Resources   | <input type="checkbox"/> Primary or Specialty Medical Care | <input type="checkbox"/> Nutritional Support     |
| <input type="checkbox"/> ADA Accommodations (if recommended, additional documentation will be required)                 | <input type="checkbox"/> On-Campus Housing                 | <input type="checkbox"/> Special Needs Housing   |
| <input type="checkbox"/> Medication Management  | <input type="checkbox"/> Reduced Academic Course Load      |  |
|   | <input type="checkbox"/> 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:

**Office of Student Care Coordination**

**ATTN: MLOA/Health Records**

PMB 351508, 2301 Vanderbilt Place

Nashville, TN 37235-1508

Email: [studentcare@vanderbilt.edu](mailto:studentcare@vanderbilt.edu)