FREDONIA
STATE UNIVERSITY OF NEW YORK

Questionnaire for Return from Medical Withdrawal | Leave of Absence

Instructions: This form is to be completed by a licensed medical and/or mental health provider (not a family member or relative). For general medical conditions which necessitated a leave/withdrawal from the university, this form should be completed by the licensed medical provider from whom you received care. If the medical leave was for a mental health condition(s) (e.g., mood disorder, alcohol or other drug disorder, eating disorder, etc.) this form should be completed by the licensed mental health professional from whom treatment was received. *This documentation should be sent by January 1 (for spring semester), May 1 (for summer sessions), or August 1 (for fall semester).*

Student's Legal Name: _____ **Student's DOB:** _____

Student's F#: _____ **Summary of Treatment attached** (see letter)**: YES NO**

Please circle the discipline(s) in which you have an active license:

• Psychiatry • Psychology • Mental Health Counseling • Clinical Social Work

• Marriage and Family Therapy • Physician/Nurse Practitioner/Physician's Assistant

• Other _____

Did you provide treatment for the above named student? • Yes • No

To date, how many treatment sessions/office visits have you provided for the student related to the reason for their medical/psychological leave? _____

Please indicate any specific treatment (medications, surgery, physical therapy, etc.) **or treatment program** (e.g. Outpatient therapy/treatment, partial hospitalization, inpatient hospitalization, etc.) **the student participated in while on leave:**

Has the aforementioned student successfully completed treatment? • Yes • No

On what date did the treatment commence? _____

On what date did the treatment conclude? _____

If the student has not completed treatment, describe the on-going treatment plan:

Has the treatment plan for the client's/patient's condition included the use of prescription medications?

- Yes • No

If yes, please indicate medication(s), dosage, and schedule:

What are the continued care/treatment needs for this student?

Signature of Provider: _____ **Date:** _____

Name of Provider (please print): _____

Title and License of Provider: _____

Address of Provider: _____

Phone #: _____ **Fax #:** _____

Releases of Information obtained & copies attached: YES NO

Please return to:

Executive Director of Student Wellness & Support
SUNY Fredonia
702 Maytum Hall
Fredonia, NY 14063
Tel: 716-673-3271 | Fax: 716-673-3583
student.affairs@fredonia.edu