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**Dean of Students Office**
939 Main Street, Office 214 (Location)
950 Main Street (Mailing)
Worcester, MA 01610-1477
Phone 508-793-7423 Fax 508-793-8847

**Medical Provider Report for Return from Medical Leave Absence**

**Student Name**: Click here to enter text.

**Student Date of Birth**: Click here to enter text.

**Medical Provider Name and Credentials**: Click here to enter text.

**Medical Provider Address**: Click here to enter text.

**Medical Provider Phone Number**: Click here to enter text.

**Summary of Treatment Provided**

**Dates of Treatment**: [from] Click here to enter a date. [to] Click here to enter a date.

**How many sessions have you provided the student (related to this matter**)? Click here to enter text.

**Was the student compliant with the treatment**? [ ]  Yes [ ]  No

**Briefly describe the student’s problems as you see them and include all diagnoses. Please feel free to attach a separate page if necessary**. Click here to enter text.

**Was psychotropic medication prescribed? If yes, what was prescribed (medication, dose**): Click here to enter text.

**Has there been a significant improvement in the student’s original medical condition? Has the student addressed the issues that led him/her/them to leave school? Please explain how**: Click here to enter text.

***If applicable*, has there been a substantial reduction in any of the following safety-related behaviors in which the student may have been engaging?**

[ ]  Yes [ ]  No [ ] N/A Suicidal behaviors and/or suicide ideation

[ ] Yes [ ] No [ ]  N/A Self-injurious behavior

[ ] Yes [ ]  No [ ]  N/A Substance abuse behaviors

[ ] Yes [ ] No [ ]  N/A Failure to maintain weight at minimum of 90% of Ideal Body Weight for height

[ ] Yes [ ] No [ ]  N/A Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g., use of laxative, excessive exercise, etc)

[ ] Yes [ ] No [ ]  N/A Other: Click here to enter text.

**In your best judgment, is the improvement in the student’s condition likely to be sustained? Please keep in mind that the academic environment can be stressful, and that residence halls are unmaintained living environments.** Click here to enter text.

**Recommendations**

*Academic Enrollment Recommendations*:

[ ]  The student is ready to return to the unstructured, unsupervised and demanding academic environment on a full-time basis.

[ ]  The student is not ready to resume full-time enrollment, but it is suggested that he/she/they enroll part-time.

[ ]  The student is not yet ready to resume studies at Clark University.

*Treatment Recommendations*:

[ ]  Continued treatment is not recommended at this time

[ ]  The student will remain in treatment with this provider

[ ]  Treatment will be transitioned to another community provider

[ ]  The student will receive treatment at Clark University Center for Counseling & Personal Growth

[ ]  The student will receive treatment at Clark University Health Services

*Please note: Clark University Center for Counseling and Personal Growth offers primarily short-term care. If you anticipate that the student will require long-term treatment, we are available to provide a list of resources in the community and with the referral process.*

**Clinician Name:** Click here to enter text. **License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Clinician Signature**

**Date:**  Click here to enter a date.