ITHACA COLLEGE

Student Accessibility Services

Return from Health Leave of Absence (HLOA) — Health Care Provider Form

Instructions: This form is to be completed by the student's licensed health care provider and can be returned to Heather Crider at Student Accessibility Services by fax to **607-274-3957** or by email to **sas@ithaca.edu**.

Student name: _____ Student D.O.B: _____

Provider name: _____ License #: _____

Provider licensed as: _____ State of licensure: _____

Provider email: _____ Provider phone: _____

Dates of treatment (first session and most recent): _____

For what functional reason(s) did this student need to take a Leave of Absence? Please include any relevant diagnoses (DSM-V and/or ICD-10):

What treatment(s) has the student completed during their leave of absence? (e.g., programs, hospitalization, procedures, treatment modalities).

In your professional opinion, has there been a substantial and stable amelioration of the functional reason(s) which necessitated a Leave of Absence? If yes, how so?

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Have you observed in this student a significant reduction in (check all that apply):

___ Number of symptoms

___ Persistence of symptoms

___ Severity of symptoms

___ Functional impairment

___ Subjective level of client distress

Please use the space below to let us know, in your professional judgement, this student will be able to continue pursuing their education at Ithaca College, given the academic and community standards associated with a residential college environment.

Are there any relevant factors or treatment plans IC should be aware of, in order to support this student's return?

Please include any special considerations from which this student may benefit, once they return to campus. If the student may need accommodations, please include how the student's disability can be impacted by the environments at Ithaca College. This should be information pertaining to the frequency, severity, and pervasiveness of the disability, as well as any known triggers on campus.

Provider signature: _____ Date: _____