ITHACA COLLEGE

Student Accessibility Services

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): _____

In your professional opinion, for what reason(s) does this student need to take a leave of absence? Please include any relevant diagnoses (DSM-V and/or ICD-10):

_____

_____

_____

Please share any relevant treatment plans (programs, hospitalization, procedures, etc) and their expected duration / recovery time:

_____

_____

_____

Other relevant clinical information: _____

_____

_____

_____

Provider signature: _____ Date: _____