Dear Licensed Medical/Mental Health Professional:

Your patient/client has taken a medical withdrawal/leave of absence from the State University of New York at Fredonia. When this student is interested in returning to Fredonia to pursue their education, the student must provide verification from a licensed professional that:

- The student has followed through with a course of treatment appropriate to the condition(s) which necessitated their departure from the university,
- The student is ready to resume academics and university life.

To help facilitate this process, **please complete and return the following to Enrollment and Student Services (2121 Fenton Hall, SUNY Fredonia, Fredonia, NY 14063):**

- *Questionnaire for Return from Medical Withdrawal | Leave of Absence* (attached)
- *A completed release of information*, signed by the student, which will permit you to communicate with any clinical provider of the Fredonia *Health* or *Counseling Center* (as appropriate). Our communication with you in this matter will be essential in the reenrollment consideration process for the student.

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#: _____ **Student's current phone number:** _____

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

If no, please provide the name of the primary provider: _____

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?

Please provide your professional opinion about whether the student is ready to resume academics and university life at Fredonia:

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:

Enrollment and Student Services
SUNY Fredonia
2121 Fenton Hall
Fredonia, NY 14063
Tel: 716-673-3271 | Fax: 716-673-3583
Email: ESS@fredonia.edu