SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE

Medical Leave of Absence Provider Readiness to Return Form

Southern Illinois University Edwardsville is committed to supporting the health, safety, and welfare of its students and preserving the integrity of its learning environment. The purpose of a medical leave of absence is to provide students with time away from campus for the treatment of a medical or behavioral health condition that significantly impacts their ability to function safely or successfully as a member of our community.

To the view the policy in its entirety, please visit: https://www.siue.edu/policies/table-of-contents/3c16.shtml

This form must be completed by the student's licensed medical and/or behavioral health service provider. This form may be brought to the Dean of Students Office (Rendleman 2306), emailed to deanofstudents@siue.edu, or faxed to 618-650-3388 (Attn: Dean of Students Office)

Provider Information

Provider name		Street Address	
License Type		License Number	
State of Licensure		Telephone	
Clinic/Hospital Name		Email Address	

Student Information

Student name:		Date of Birth:	

Treatment Summary

Date of First Contact		Date of Last Contact	
Total # of Contacts		Frequency of Contacts	
Medical Condition			
Type of Treatment (check all that apply)	☐ Medical ☐ Psychological/Mental Health ☐ Psychiatric ☐ Substance Use ☐ Other (specify)		
Did the focus of student's treatment sufficiently address the reasons for withdrawal? ☐ Yes ☐ No			
Has the student been compliant with treatment? ☐ Yes ☐ No			

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Has there been a substantial amelioration of the student's condition? *If yes, please check all of the following that you have observed a marked reduction in*: ☐ Number of Symptoms ☐ Severity of Symptoms ☐ Persistence of Symptoms ☐ Functional Impairment ☐ Subjective level of distress	
Please describe the student's current clinical status	
Please explain the reasons you believe this student is ready to return to SIUE after a Medical Leave of Absence, including the ability to successfully resume academics, day-to-day functionality, and University life, with and without reasonable accommodations	
If you do not believe the student is ready to return, please explain:	
Do you have any concerns about the student's capacity to carry out appropriate self-care for continued well-being?	☐ No Concerns ☐ Minor Concerns ☐ Moderate concerns ☐ Student is unable or unwilling to carry out appropriate self-care
If you have indicated moderate or unable/unwilling, please explain your rationale and provide any recommendations for mitigating these concerns:	
Do you have concerns about the student in regards to the safety of themselves or others?	☐ No Concerns ☐ Minor Concerns ☐ Moderate concerns ☐ Student presents an actual risk of serious harm to self or others
If you have indicated either moderate concern or you believe the student presents a risk, please explain your rationale and provide any recommendations for mitigating these concerns:	

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Please check the following activities of which you believe the student is presently capable:

☐ Attend a lecture of up to 3 hours in length
☐ Spend hours in study, maintain concentration, and grasp complex material
☐ Organize and write papers
☐ Balance academic demands with extracurricular activities
☐ Manage social relationships
☐ Manage daily living skills (hygiene, adherence to medication regimen, share community living space, respect for reasonable needs of others) so as to live independently in residential housing
☐ Manage behaviors such as self-regulation, calming self
☐ Student is capable of carrying an academic course load at an academically rigorous institution.

Is the student able to return safely to school without limitation? ☐ Yes ☐ No

Is the student able to return safely to campus housing without limitation? ☐ Yes ☐ No

If no, identify all current major life activities affected by the diagnosis and describe the severity of the student's functional limitations resulting from the disability:	

Provider Attestation

☐ I believe this student IS medically/psychologically stable and therefore ABLE to return to SIUE as a student.

☐ I believe that this student IS NOT medically/psychologically stable and therefore NOT ABLE to return to SIUE as a student.

By signing below, you affirm that the information set forth above is true and accurate to the best of your knowledge.

Signature
Signature of the Person Submitting this Form

Name
Name of the Person Submitting this Form (print)

Date
(MM/DD/YYYY)