SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE

Medical Leave of Absence Provider Recommendation 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 Information

Date of First Contact		Date of Last Contact	
Total # of Contacts		Frequency of Contacts	
Onset Date/Most Recent Exacerbation:			
Medical Condition			
Type of Treatment (check all that apply)	☐ Medical ☐ Psychological/Mental Health ☐ Psychiatric ☐ Substance Use ☐ Other (specify)		
Relevant medical or behavioral health history			

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Please describe your treatment of the student for this condition(s). *Nature of treatment*: *Medications*: *Response to treatment*:	
Impact of the condition(s) on student's academic and overall functioning and how it significantly limited student's ability to function successfully or safely in their role as a student	
Do you intend to continue treating this student while on Medical Leave?	☐ Yes ☐ No
If not, do you recommend that the student continue to be treated while on a Medical Leave of Absence? *Please provide specifics as to the frequency, type, duration of treatment, and type of provider*	☐ Yes ☐ No
If so, what is the recommended type of treatment?	
Please provide your professional recommendations regarding treatment or care for the management of this student's condition(s), with a focus on what treatment and supports will help the student to transition back to enrolled student status.	
Expected outcome of treatment during the leave period	
What needs to be clinically different/improved to safely and successfully return	
For retroactive requests: How did the student's condition impact their ability to withdraw on time?	

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

Signature _____ Name _____

Signature of the Person Submitting this Form

Name of the Person Submitting this Form (print)

Date _____

(MM/DD/YYYY)