



## Request to Return from Medical Leave- Readiness Assessment

### Part 1: Completed by Student

Student Full Name: \_\_\_\_\_ Student ID Number: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ MSU Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Personal email address: \_\_\_\_\_

Please indicate the term you are requesting to return from medical leave :

Fall Term \_\_\_\_\_ (year)       Spring Term \_\_\_\_\_ (year)       Summer Term \_\_\_\_\_ (year)

### Acknowledgements

\_\_\_\_\_ Student initials: I understand the Office of Student Support and Accountability may audit my form to ensure the information provided is accurate and this may include contacting my treatment provider.

\_\_\_\_\_ Student initials: I authorize my treating provider(s) to communicate with OSSA at Michigan State University regarding this request to return from medical leave. This consent will automatically expire when a determination is made regarding my readiness to return request.

*By providing this form to my licensed treatment provider, I understand they will complete it using my personal health information and I will send it to the Office of Student Support and Accountability (OSSA) at Michigan State University for my request to Return from Medical Leave to be reviewed. Only the information requested and shared specifically on this form will be reviewed by the staff within OSSA at MSU. I understand that my provider may have additional requirements related to patient/client privacy.*

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Part 2: Completed by Treatment Provider

**Attn. Provider:** The above-named student is seeking re-enrollment following a medical leave. Please note that no other documentation will be reviewed. Since students are limited to two Medical Leaves, in the interest of student health and success, they are asked to work closely with their treatment provider(s) to determine their readiness to return to the academic environment. The student's return request must be accompanied by this form.

Provider Name: \_\_\_\_\_ State or country of licensure: \_\_\_\_\_

Professional Credentials: \_\_\_\_\_ Provider phone number: \_\_\_\_\_

Professional License #: \_\_\_\_\_ Provider email address: \_\_\_\_\_

### ASSESSMENT QUESTIONS

- Is the student's condition primarily related to:     physical health     mental health     combination
- Number of Appointments Attended: \_\_\_\_\_
- Dates of Treatment: \_\_\_\_\_ to \_\_\_\_\_

4. Please outline the specific observed changes in the student's functioning, and/or general ability to participate and be successful in the academic environment.
- Ex: ability to function safely as a full-time student (manage stress, concentrate, manage interpersonal relationships, etc.)

5. Your recommendation regarding the student's readiness to return to academic enrollment (including handling stress, focusing for significant periods of time, etc.)
- Student is **READY** to resume academic enrollment
  - Student is **NOT READY** to resume academic enrollment

Please provide rationale for your selection (required):

OSSA works to connect students returning from medical leave with campus resources and opportunities that support their overall well-being and success.

6. If you recommend that the student is ready to resume:
- a. Do you have any recommendations for on-going treatment, non-clinical resources, activities or opportunities to support their personal/academic success?

\_\_\_\_ (Provider's Initials): I understand the Office of Student Support and Accountability at Michigan State University may contact me to verify the information provided. Sign below to confirm this form has been completed by the licensed treatment provider to the student or designee.

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Providers should return the completed form to the student. Student can then upload to [OSSA MLRP Request form](#).**