Office of Student Support and Accountability
MICHIGAN STATE UNIVERSITY

Contact OSSA
Email: ossa@msu.edu
Phone: 517-884-0789
https://ossa.msu.edu/medical-leave

Request for Medical Leave- Treatment Provider 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(s) you are requesting the medical leave for:

☐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 for a medical leave. This consent will automatically expire when a determination is made regarding my request for a medical leave.

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 for 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 has requested a Medical Leave from Michigan State University. A Medical Leave is a designation that indicates a student experienced a health condition that had catastrophic impact on their ability to maintain enrollment. This form must be completed by a licensed treatment provider who provides treatment to the student. Please complete each section completely and with as much detail as possible.

Provider Name: ______________________________ **State or country of licensure:** ____________________

Professional Credentials: ______________________ **Provider phone number:** ________________________

Professional License #: ________________________ **Provider email address:** ________________________

Assessment Questions

1. Is the student's condition primarily related to: ☐physical health ☐mental health ☐combination

2. Number of Appointments Attended:_________

3. Dates of Treatment: ___________ to ___________

4. Do you believe the student's condition(s) has a catastrophic impact on their academic progress, functioning, and/or ability? ☐Yes ☐No ☐ Unable to determine

IF YES: Please provide detailed information about how the medical condition(s) affects or has affected their academic progress, functioning, ability and/or general ability to participate in the academic environment.

5. Do you believe the student's condition(s) had a catastrophic impact on their ability to enroll during the term the student is requesting the medical leave for (in Part 1)?
   ☐Yes ☐No ☐ Unable to determine

IF YES: What is the general time frame of the condition impact? ___________ (mm/yy) to __________(mm/yy)

OSSA's goal is to ensure students are ready to return to MSU from a medical leave. We recognize the financial, mental, and personal investments of being a full-time student. When a student is granted a medical leave, most are expected to take at least one semester off to prioritize and focus on their health.

Please answer the following question based upon your current assessment (NOT projected assessment).

6. In your professional opinion, has the student made sufficient progress with the condition(s) to demonstrate they are ready to re-enroll and be successful?

   ☐Yes ☐No ☐ Unable to determine

IF NO or UNABLE TO DETERMINE: Please briefly describe key elements of the care plan that will aid the student in their progress back to enrolled status.

7. Is there any additional information or comments you would like to share with OSSA regarding the students' request? (optional)

____ (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 student. Student can then upload to OSSA ML Request Form.