Treatment Provider Report Form – Request for Medical Leave

Michigan State University

PART 1: To be completed by the Student

Student Full Name: Preferred Name:

Student ID Number: MSU Email Address:

Requested term for withdrawal (e.g. Fall 2023):

_____ (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 health care provider(s) to communicate with the Office of Student Support and Accountability at Michigan State University regarding this request for a leave of absence for medical reasons. This consent will automatically expire when a determination is made regarding my request for a leave of absence.

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 in order 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: To be completed by the Licensed Treatment Provider

1. The above named student has requested a Medical Leave from Michigan State University, stating they have/had a medical condition that prevented them from meeting the expectations of a student during their above requested term. A Medical Leave initiates a **complete withdrawal** from all courses due to a medical condition which caused a catastrophic impact on a student's ability to remain enrolled.
2. This form must be completed by a licensed treatment provider who provides treatment to the student.
3. No other medical documentation will be reviewed. Please be as specific as possible on this form.

Provider Name: **Professional Credentials:**

Professional License #: **State (or Country) of Licensure:**

Provider Phone Number: **Provider Email:**

Dates of treatment: _____ to _____ **Number of appointments attended**: _____

For tracking/trend purposes only

Is the student's condition **primarily** related to: ☐ Physical health ☐ Mental health

Assessment

1. Do you believe the student's medical condition affects or has affected their academic progress, functioning, and/or ability?

   ☐ Yes ☐ No ☐ Unable to determine at this time

   If "Yes", REQUIRED information about impairments which impacted their progress, functioning, and/or ability:

2. Do you believe the student's medical condition had a catastrophic impact on their ability to remain enrolled during the term for which they are requesting a Medical Leave (reference Part 1 of this form)?

☐ Yes ☐ No ☐ Unable to determine at this time

If "Yes", REQUIRED general time frame the condition impacted their ability to remain enrolled (e.g. Sept – Nov 2022, 1/15/23 – 3/1/23, Spring 2023 – present):

3. Recognizing the financial, mental, and personal investments of being a full-time student, our goal is to ensure students are ready to return to MSU from a medical leave. **With medical leaves, most students take at least one semester off from MSU to prioritize and make progress with their health.** In rare circumstances, this is not necessary.

We seek your responses to the following questions, based upon your **current** (NOT projected) assessment of the student's medical condition.

- Is the condition predictably time-limited and highly likely to resolve on its own?

  ☐ Yes ☐ No ☐ Unable to determine at this time

- Is it highly likely the condition will be successfully managed by the student without any additional treatment (NOT including continued treatment to maintain and monitor progress with the condition)?

  ☐ Yes ☐ No ☐ Unable to determine at this time

- Has the student made sufficient progress with the condition to demonstrate they are currently ready to re-enroll:

  ☐ Yes ☐ No ☐ Unable to determine at this time

If "Yes" provided for ANY of the three previous bulleted questions, REQUIRED rationale for selection(s):

____ (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/Designee Signature: Date:

When complete, return this form to the student/patient/client, who will then share it with MSU for consideration of a Medical Leave.

Office of Student Support and Accountability – Michigan State University

https://ossa.msu.edu/medical-leave Phone: (517) 884-0789