Saint Joseph's University
Return from Medical Leave Form

To the Student: Please have this form completed by your current health care or mental health care provider. This form assesses readiness to resume study at SJU. Please be aware that this form must be submitted no later than 2 weeks prior to the first day of classes. The Form must be submitted to:

Director of Student Disability Services
Saint Joseph's University
5600 City Avenue – G10 Bellarmine Hall
Philadelphia PA 19103
Email – sds@sju.edu
Fax- 610-660-3053

I give permission for the Saint Joseph's University Medical Leave Committee to review this documentation:

Student Name:___________________________________ SJU Student ID: _____________________________

Student Signature: ________________________________ Date: _____________________________________

To the Health Care Provider: The student named below has been on a medical leave from Saint Joseph's University. In order to return to SJU the student must demonstrate that the medical condition has been sufficiently resolved and that the student is ready to resume academic and/or residential activity on campus. The information on this form will be used in processing and evaluating the student's request to return to SJU. Please be as detailed as possible when answering questions regarding the treatment you provided and your impressions regarding the student's readiness to return to school.

Patient Name:_________________________ Date of Birth: ____________________________

Diagnosis:_____________________________ Date of Diagnosis:___________________________

Duration of treatment by this provider:____

Please provide a brief description of the student's current medical and/or psychological status:

____
____
____
____

Current treatment modalities and recommendations regarding continuation:

Medications

Current:____

Recommendation regarding continuation: ____

Physical Therapy

Current:____

Recommendation regarding continuation: ____

Nutritional Therapy (not available on campus)

Current:____

Recommendation regarding continuation: ____

Individual Therapy

Current:____

Recommendation regarding continuation: ____

Group Therapy

Current:____

Recommendation regarding continuation: ____

Other

Current:____

Recommendation regarding continuation: ____

Please evaluate the limitations experienced by the student as a result of their medical condition in the following categories as they relate to academic performance.

Concentration: ___ mild ___ moderate ___ severe ___ n/a Comments:

Reading: ___ mild ___ moderate ___ severe ___ n/a Comments:

Writing: ___ mild ___ moderate ___ severe ___ n/a Comments:

Ability to Attend Class: ___ mild ___ moderate ___ severe ___ n/a Comments:

Other: ___ mild ___ moderate ___ severe ___ n/a Comments:

Please evaluate the student's current level of risk.

Risk of instability of medical condition: ___ low ___ moderate ___ high ___ n/a Comments:

Suicide risk: ___ low ___ moderate ___ high ___ n/a Comments:

Violence risk: ___ low ___ moderate ___ high ___ n/a Comments:

Self injury risk: ___ low ___ moderate ___ high ___ n/a Comments:

Please indicate how you have obtained the information used to complete this form:

___ I have examined and/or treated this student.

___ I have not examined and/or treated this student but have used review of documents/charts and/or consultation.

Please indicate your conclusion:

In my opinion this student is medically stable and able to return to Saint Joseph's University as a full time student.

Yes **No** **Unable to Judge**

In my opinion this student is psychologically stable and able to return to Saint Joseph's University as a full time student.

Yes **No** **Unable to Judge**

In my opinion this student is medically stable and able to return to residential life at Saint Joseph's University.

Yes **No** **Unable to Judge**

In my opinion this student is psychologically stable and able to return to residential life at Saint Joseph's University.

Yes **No** **Unable to Judge**

Please provide your contact information:

Provider Name: ____

Provider Signature: ____

Date: ______________________________ License Number: _______________________________

Telephone number: __________________ Fax Number: ___________________________________