

**REASON FOR A MEDICAL LEAVE OF ABSENCE
PROVIDER DOCUMENTATION FORM**

Student Name: _____ **Date of Birth:** _____

Semester for which the student is requesting a MLOA: _____ / _____
Semester Year

Instructions for the Health Care Provider:

- The above-named student is seeking to take a medical leave of absence (MLOA) from WashU
- Please complete this page to substantiate the student's request and return via email or fax

Expectations During A MLOA:

While on MLOA, it is expected that the student will continuously engage in treatment until their provider determines that the concerns that led to the leave of absence are adequately addressed. In order to successfully reinstate back to WashU after a MLOA, a student must participate in the appropriate level of care to address their concerns, as determined by a medical/mental health profession.

Treatment Information:

Current Diagnosis(es) (if applicable): _____

Current Medications (if applicable):

Medication	Date Started	Dosage/Frequency	Stable	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

What are the recommendations for continued medication management while the student is on leave? (if applicable):

Will you continue to provide care for the student during their MLOA? ☐ Yes ☐ No

If not, have follow-up services been arranged for when this student leaves campus? ☐ Yes ☐ No

Treatment provider information (if available): _____

What is the recommended course of treatment or plan for recovery? Please check the box(es) below:

- | | |
|--|---|
| ☐ Alcohol / other drug support | ☐ Physical therapy |
| ☐ Eating disorder support | ☐ Psychiatric support |
| ☐ Intensive outpatient treatment | ☐ Residential treatment |
| ☐ Occupational therapy | ☐ Specialty medical care |
| ☐ Outpatient mental health counseling | ☐ Surgery |
| ☐ Partial Hospitalization program | ☐ Other: _____ |

In the box below, please specify details you recommend and indicate the expected duration of the treatment / recovery. This helps us better support students while they are on MLOA and set expectations on when they may be ready to return.

Have you discussed the above treatment recommendations with the student? ☐ Yes ☐ No

Is the student in agreement with these recommendations? ☐ Yes ☐ No

Provider Name: _____

Provider Title: _____

Phone number: _____

Signature: _____ **Date:** _____

- To maintain F-1 student visa status, international students must have the form signed by a licensed medical doctor, Doctor of Osteopathic Medicine, clinical psychologist, or psychologist.
- All documentation must be submitted in the English language from the health provider(s); or translated by a licensed professional translation service for review. Students are welcome to use the professional licensed service of their choosing.