WashU Cares MLOA team
Danforth University Center, One Brookings Drive, 63130
Phone: 314.935.5956
Fax: 314.970.9093
Email: studentmedleave@wustl.edu

WashU

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 on Current Dose?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

What are the recommendations for continued medication management while the student is on leave? (comment on doses that are not stable if applicable):

_____

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

If you are a WashU provider, have you acquired administrative permission to provide care for the student during their MLOA? ☐ Yes ☐ No

WashU Cares MLOA team
Danforth University Center, One Brookings Drive, 63130
Phone: 314.935.5956
Fax: 314.970.9093
Email: studentmedleave@wustl.edu

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:

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

In the box below, please specify details of the recommended items checked above. Where possible, indicate the expected duration of the treatment and markers of 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.