Leave of Absence Return
Provider Information Form

Please fill out the form below and attach appropriate supplemental documentation for your client_____.
Thank you in advance for your support and cooperation.

Practitioner Name/Title_____Date_____

Address_____

Telephone_____FAX_____

Specialty/qualification to make diagnosis_____

1. Diagnosis, instruments and procedures for diagnosis, date of diagnosis and dates of attendance/clinical visits.

   _____

   _____

   _____

2. Describe the treatment provided.

   _____

   _____

   _____

3. Severity of condition. (Mild, Moderate, Severe)_____

4. List current medication(s), dosage frequency and adverse side effects.

   _____

   _____

5. Please indicate prognosis and recommendations for return. Each recommendation must be supported by the diagnosis.

   _____

   _____

   _____

6. Additional comments:

   _____

   _____

Signature of Specialist Date

Please note that the Clinical Care Coordinator, in consultation with appropriate University officials, will make all final decisions on readmission for any student granted a Medical Leave of Absence.

Please return the completed form and supplemental documentation to:
Clinical Care Coordinator, Fr. Scott Brookbank, OFM
(716) 375-2354
E-Mail: sbrookbank@sbu.edu