**Emmanuel College**

**Medical Leave of Absence**

**Return Documentation**

A student who returns from a medical leave should have an appropriate health provider address the questions below. If the problem is medical, a physician must complete the form. If the problem is psychological, a psychiatrist, licensed psychologist or other licensed mental health professional must complete the form. If the student has been hospitalized for mental health reasons, personnel on the hospital treatment team may appropriately complete this questionnaire. The form must be completed and signed by a psychiatrist or licensed psychologist or other treating mental health professional. The questions can be completed on the form below and attached to a brief signed statement on **professional letterhead** or the questions can be addressed in a separate statement on letterhead provided to the Counseling Center or the Health Services director.

1. Full name of student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. a. Are you a \_\_\_medical doctor, or \_\_\_psychiatrist, or \_\_\_licensed psychologist? \_\_\_\_Other (give degree)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Did you provide the treatment for the above named student? \_\_\_Yes \_\_\_No

c. How many treatment sessions have you provided for the student (relating to this matter)? \_\_\_\_\_

1. When did the treatment commence? \_\_\_\_\_\_\_\_\_\_ Conclude? \_\_\_\_\_\_\_\_\_\_\_
2. Has the above-named student completed treatment? \_\_\_yes \_\_\_no

3. Briefly describe the student’s problems as you see them. Please feel free to attach a separate page if necessary. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4. Have you referred the student for continuing treatment? \_\_\_Yes\_\_\_No

If yes, please indicate the name, address, and phone number of the individual or agency. You may wish to consult with Counseling or Health Services regarding the availability and appropriateness of referral resources in the community. **Please keep in mind that the Emmanuel College Counseling Center provides short-term, solution-focused treatment. A referral to the Counseling Center for long-term intensive psychotherapy is inappropriate for the needs of the student.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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5. Does the student require medication in order to function effectively? \_\_\_Yes \_\_\_No Have arrangements for continued medication and follow-up been made? Please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. If you have referred the student for continuing treatment, do you believe he/she would be able to function appropriately as a student at Emmanuel College **without** this continued treatment? \_\_\_Yes \_\_\_No

7. Do you consider that the student presently or in the reasonable foreseeable future may be a threat to his/her own life or the lives of others? \_\_\_ Yes \_\_\_No

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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8. Do you think this student is capable of carrying a full academic load (16 credit hours) at this College \_\_\_Yes \_\_\_No

 If the student needs accommodations for a disability, please refer student to Disabilities Support Office: <http://www.emmanuel.edu/academics/academic-resources/academic-resource-center/disability-support-services.html>

9. Would you recommend that the student live in?

 \_\_\_ a) Campus Residence Halls

 \_\_\_ b) Off-campus private housing

 \_\_\_ c) Live at home with family and commute (if feasible)

 \_\_\_ d) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain the reasons for your recommendation. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. To your knowledge, are the parents and/or legal guardian(s) of the student aware of the problem(s) for which you have provided treatment? \_\_\_Yes \_\_\_No \_\_\_Not applicable

12. Other comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Printed Name of Treating Professional Profession/Type of Specialist

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Signature of Treating Professional Date

**\*Please remember to attach a brief statement of recommendation for reenrollment and campus housing using your office letterhead.**

Return to:

Amanda Snow, Director of Counseling OR

Dr. Kristen Pierce, Dean of Students

Emmanuel College 400 Fenway

Boston, MA 02115

Counseling Center: 617.735.9920 FAX: 617.935.9919

Student Affairs: 617.735.9722