MEDICAL LEAVE (ML)
TREATMENT PROVIDER REPORT

SECTION 1: <u>To be completed by the student</u>:

Please ensure this form is completed by any and all providers who provided treatment during the ML dates listed below (i.e., primary care provider, specialist, psychiatrist, therapist, etc.). This form must be completed in full and submitted to the Student Success Center by the deadline corresponding to the relevant term of return. Incomplete or late submissions may result in a delay in re-enrollment until the next term pending submission and approval of new documents.

Deadlines for Return from ML
All information and documentation must be submitted to the Student Success Center ***six weeks prior*** to start of semester in which student seeks to return.

Student Name: ______________________________________ Date of Birth: ____/____/_____

Leave Start Date: ____/____/_____ Leave End Date: ____/____/_____

Term for which you are requesting to return from ML: __________/__________
Term Year

SECTION 2: <u>To be completed by licensed treatment provider</u>:

The above-named student is seeking to return to Ranken Technical College after taking a medical leave of absence. Please complete the following information, sign, and return this report to the Student Success Center using the contact information noted below. If necessary, attach additional documents to expand on your recommendations and the student's ability to function safely, stably, and successfully as a full-time student at this time.

Treatment Information

Current Diagnosis(es): ____

____

____

Date(s) of Treatment: ______/______/______ to ______/______/______

Total Number of Visits: ________________________

Was student compliant with treatment plan? ☐ Yes ☐ No

If no, please explain: ____

____

____

Please provide details of treatment provided: __________________________

____

____

Current Medications:

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

Recommendations for continued medication management: ___________________________________

____

____

Will you continue to provide services for this student? ☐ Yes ☐ No

If not, have follow-up services been arranged for when this student returns to campus?

☐ Yes ☐ No

Service/Provider Information: ____

Assessment of the Student:

Do you believe that this student is currently a danger to their self? ☐ Yes ☐ No

If yes, please explain: ____

____

Do you believe that this student is currently a danger to others? ☐ Yes ☐ No

If yes, please explain: ____

____

What is your assessment of the current status of the student's condition?

☐ Good ☐ Fair ☐ Poor

Has this student demonstrated an ability to maintain a schedule and function productively in conjunction with or outside of the treatment program for at least 3 months? This could include holding a full- or part-time job, pursuing regular volunteer work, taking a college-level course, or other productive activities.

☐ Yes ☐ No

If no, please explain: ____

____

Do you have any reservations regarding this student's full-time enrollment in the rigorous academic environment at Ranken Technical College in the upcoming semester?

☐ No Reservations ☐ Reservations

Please explain: ____

____

Recommendations for Support Services:

Please indicate which of the following options would be beneficial for the student when they return to campus and provide specific recommendations in the box below that will help the student succeed. Check all that may apply. (Examples of specific recommendations may include: "Student would benefit from biweekly CBT sessions for continued treatment of anxiety;" "Student would benefit from weekly AA meetings and follow-up with psychiatry in 30 days for continued management of Celexa.")

Specific Recommendations:

- ☐ Psychological Counseling
  - ☐ Group
  - ☐ Individual
- ☐ Drug & Alcohol Resources
- ☐ ADA Accommodations (*if recommended, documentation will be required*)
- ☐ Psychiatric Follow-up
- ☐ Primary or Specialty Medical Care
- ☐ Medication Management
- ☐ Reduced Academic Course Load
- ☐ Eating Disorder Support
- ☐ Nutritional Support
- ☐ On-Campus Housing
- ☐ Special Needs Housing

☐ Other: ____

Have you discussed these recommendations with the student? ☐ Yes ☐ No

Does the student agree to these recommendations? ☐ Yes ☐ No

MEDICAL CARE PROVIDER INFORMATION/SIGNATURE

(*We may contact you with a request for more detailed information*)

Provider name: ____

License Number: ________________________

Credentials/Profession: ____

Area of Medical/Mental Health Specialty: ____

Address: ____

Phone: ________________________ Email: ____

Signature: _____________________________________ Date: ______/______/______

<u>Please complete in full and return by mail or email to</u>:

Ranken Technical College
Student Success Center
ATTN: ML/Health Records
4431 Finney Ave., Rm. 209
St. Louis, MO 63113
Phone: (314) 286-4891
Email: ssc@ranken.edu