NOTE: This form is to be completed by the student’s mental health clinician/service provider and mailed by the provider directly to the following address: **Community Standards, Room 349, Baker University Center, One Park Place, Athens, OH 45701**.

Clinician Name: _________________________  Student Name: _________________________

Licensed as: _________________________  Student’s OU ID#: _________________________

License #: _________________________  Date of First Session: ______________

State of Licensure: ___________  Total # of Treatment Sessions: _______

Clinician Phone #: _________________________

As part of this person's treatment there needs to be a bio-psycho-social assessment of functioning: please provide your professional judgment in response to the following questions regarding the student named above:

**Presenting Problem(s) & Diagnostic Impressions:**

**Treatment Summary:**

Is this individual ready to assume responsibility for stable academic functioning (i.e. refrain from violating the student code of conduct, focus on academic work and participate socially):

**Recommendations for continued care or ability to function without support:**

Please use the back of this page or attach additional documentation if you wish to expand on your responses or if you have any other comments or observations you may wish to make regarding this student and his or her ability to function safely, stably, and successfully as a full time university student at this time.