Readiness to Return from Medical Withdrawal Form (Provider Report)

This form and a professional assessment **must be completed by the student's physician / mental health clinician / service provider** and be sent directly from the provider to the Office of the Dean of Students by either:

Fax
740.597.3301

OR

United States Mail
Office of the Dean of Students
345 Baker University Center
1 Ohio University Drive
Athens, OH 45701

Student Information (to be completed by the student)

Last Name ______ First Name ______ Middle Initial ______

PID P______

Provider Information

Last Name ______ First Name ______ Middle Initial ______

License Number ______

Licensed As / Licensure Type ______

State of Licensure ______

Date of First Visit w/ Student ______

Date of Most Recent Visit ______

Total Visits (Last 3 Months) ______

Address ______

Phone Number ______

Fax Number ______

Professional Assessment

☐ Please provide detailed information related to the medical and/or psychological condition of the student. Please send a written assessment on clinical letterhead, including: the initial on-set of the condition; the type, frequency and severity of symptoms; and treatments necessary to alleviate symptoms; and why you feel the student can return to the university. The written assessment and this document should be faxed or mailed as per the directions as the top of the form. In addition, please provide any recommended follow up to aid in the success of the student.

Assessment Summary

☐ What date did the student first seek treatment? ______

☐ Is the student medically able to return to the university? ☐ Yes ☐ No

Provider Signature ______

Date ______

OHIO UNIVERSITY 1804
DIVISION OF STUDENT AFFAIRS

Office of the Dean of Students
345 Baker University Center • 1 Ohio University Drive • Athens, Ohio 45701
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