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 | P PID

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