Office of the Dean of Students

PROVIDER RETURN FROM MEDICAL LEAVE OF ABSENCE (MLOA) FORM

Please type or print neatly in ink and complete all sections.

Section I: To be completed by student:

Student Name: _____ Student ID #: _____

Phone #: _____ Email: _____

Semester you are requesting to return from MLOA: ☐ Fall ☐ Spring Year: _____

By signing I authorize my treatment provider to release the requested information to Claremont McKenna College's (CMC) Dean of Students or designee. I understand this information will be reviewed by the Dean of Students who may share this information with other CMC officials, as necessary, for the purpose of reviewing my request to return from my Medical Leave of Absence (MLOA).

Signature: _____ Date: _____

Section II: To be completed by licensed treatment provider:

The above student is currently on a MLOA from CMC and is indicating readiness to return to full academic participation. The student reports that you evaluated or treated them during their leave. Please provide the information requested below then sign and forward the form to the Dean of Students Office at the address noted below.

Part A: Provider's assessment and treatment of the student:

1. ☐ medical in nature ☐ psychological in nature ☐ AOD concerns ☐ other _____
2. Date(s) of treatment/assessment: _____ to _____
3. Total number of sessions/appointments: _____
4. Current diagnoses (if any) _____
   relevant to the MLOA: _____
   _____
5. Medications prescribed (if any) _____
   relevant to the MLOA: _____
   _____

6. Prognosis (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

7. Will you continue to provide services for this student? ☐ yes ☐ no

8. If not, to whom will the student's care be transferred? _____

9. Other recommendations _____
   for follow up? _____
   _____

Part B: Your recommendation

1. Based on your current evaluation, do you believe the student is now able to meet the responsibilities of a student? ☐ yes ☐ no

   Comments: _____
   _____
   _____

2. Do you have any reservations regarding the student's full time enrollment in a high intensity academic environment? ☐ yes ☐ no

   Comments: _____
   _____
   _____

Part C: Provider Information

Name: _____

License # and State: _____

Area(s) of Specialization: _____

Address: _____ Phone: _____

Signature: _____

Please complete in full and submit to:

Dean of Students Office
Heggblade Center
850 Columbia Avenue
Claremont, CA 91711
Telephone: 909-621-8114
Fax: 909-621-8495