Request to Return from Medical Leave of Absence:

Licensed Mental Health Provider

For the Student to Fill Out:

Full name of student: _____

Date or term your LOA began: _____

Date or term you are requesting to return from LOA: _____

DIRECTIONS for Provider:

1. Fill out this form in its entirety (don't forget to sign & date)
2. On your letterhead, please write treatment summary & your recommendation for readmission to WPI.
3. **Fax this form and letter** to the SDCC at 508-831-5139.

For the Mental Health Provider to Fill out:

Are you a: ☐ Psychiatrist ☐ Licensed Mental Health Professional

☐ Psychologist ☐ Clinical Social Worker

☐ Other Licensed Mental Health Professional: _____

Did you provide treatment for this student? ☐ Yes ☐ No

How many treatment sessions have you provided for the student? _____

Please indicate any specific treatment program student participated in while on leave (E.g. Outpatient therapy, partial hospitalization, inpatient, etc):

_____

Has the student completed treatment? ☐ Yes ☐ No

If the student has not completed treatment, how frequently will they need to see you?

_____

When did the treatment commence? _____ Conclude? _____

Are you continuing to provide treatment when this student returns to WPI? ☐ Yes ☐ No

Have you referred the student for continued therapy off campus? ☐ Yes ☐ No

If yes, please indicate the name, address, and phone number of the individual or agency:

_____

While you were working with this student, were medications prescribed by you or another provider?

☐ Yes ☐ No

If yes, please indicate medication(s) and dosage:

_____

Will the student remain on these medications when they return to WPI? ☐ Yes ☐ No

If yes, who will be prescribing these medications when they return to WPI?

_____

Have you referred the student for continued medication management? ☐ Yes ☐ No

If yes, please indicate the name, address, and phone number of the individual or agency:

_____

To your knowledge, are the parents or guardian(s) of the student aware of the problem(s) for which you have provided treatment? ☐ Yes ☐ No

While in your care were there any safety concerns (suicide risk, homicide risk, etc)? ☐ Yes ☐ No

If yes, please explain:

_____

Other information or comments to assist in a successful transition to WPI:

_____

_____

_____

Signature of Treating Provider **Date**

_____

Name, Address, & Phone Number of Treating Provider (please print or type)