



Office of the Dean of Students

MEDICAL LEAVE OF ABSENCE PROVIDER REPORT 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 which you are requesting a 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 Medical Leave of Absence request (MLOA).

Signature: _____ Date: _____

Section II: To be completed by licensed treatment provider:

The above student has requested a MLOA from CMC due to a medical or mental health condition preventing the student from meeting the responsibilities of a CMC student during the above indicated semester. The student reports that you evaluated or treated them during that time period. Please complete this form in its entirety, sign it, and forward 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. Diagnoses related to the _____
concerns of this request: _____

5. Medications prescribed _____
related to this condition: _____

6. Status during the time period of the requested MLOA: Acute/Critical Chronic/Recurrent

7. Duration of the condition (period of time during which the student would not have been able to meet the responsibilities of a student): _____

8. Prognosis (check one): Excellent Good Fair Poor

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

10. Recommendations for _____
follow up/treatment? _____

Part B: Your recommendation

1. Do you believe that the student, due to the condition(s) described above, was unable to meet the responsibilities of a student during the time period of the requested MLOA? Please include additional information and/or documentation as necessary. yes no

Comments: _____

2. Do you support a MLOA for the student for the requested academic term? 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