VILLANOVA UNIVERSITY

PHYSICAL HEALTHCARE PROVIDER FORM
***Request to Return** from Medical Leave Absence*

Section 1: To be completed by the student

Student Name: _____Date of Birth: _____ Banner ID: _____

Semester and Year for which you are requesting to return from your MLOA: _____

I understand and consent to the following: The information below will be reviewed by the Dean or their designee, and the Director of the Student Health Center or the University Counseling Center. I understand that the Dean of the College or designee may share this information with other Villanova University officials, as necessary, for the purpose of review of the Medical Leave of Absence (MLOA) request.

Student Signature: _____ Date:_____

Section 2: To be completed by licensed treatment provider.

This is to be completed by the student's treating physician, licensed mental health provider, or other licensed healthcare provider. The provider must be an impartial diagnostician who does not have an immediate familial relationship with the student.

Providers: The above named student has previously been granted a Medical Leave of Absence from Villanova University, and is indicating readiness to return to full academic participation. The student reports that you evaluated or treated him/her/they while on a Medical Leave of Absence. Please complete in its entirety the following information regarding the student's condition. You may also write a letter, on your office letterhead, answering each item below.

- Provider's Name: _____ Provider's Title/ Degree: _____

  Provider's Area of Medical/ Mental Health Specialization: _____

  Office Address: _____

  Office Telephone: _____ Fax:_____

- Your assessment and treatment of the student
  1. ☐ Medical in nature ☐ Other_____
  2. How long have you known this student:_____
  3. Approximate date(s) of treatment/ assessment _____/_____/_____ to _____/_____/_____

4. Diagnosis & Symptoms – Please identify the student's diagnosis and the current level of functioning and degree of improvement in symptoms since start of MLOA. Please include functional impairments (if any):

_____

_____

_____

5. Treatment recommendations upon return to Villanova University:

_____

_____

_____

6. Will you continue to provide services to this student while at Villanova? Yes No
   - If No, to whom will the student's care be transferred? _____
     _____

7. Other recommendations for follow-up: _____

- Based on your current evaluation, do you believe that the student is now able to meet the expectations of a full-time student? Yes No
  Comments:_____

  _____

  _____

- Do you have any reservations regarding the student's full time enrollment in a high intensity academic environment? No Reservations Reservations (please explain)
  Comments:_____

  _____

  _____

Signature of provider: _____ Date:_____

Signed letters or forms can be mailed or faxed to:

Office for Undergraduate Students
College of Liberal Arts and Science
800 E. Lancaster Ave, St. Augustine 107
Villanova, PA 19085
Telephone: (610) 519-7429; Fax (610) 519-633
Due to COVID 19, please email form to
ousretention@villanova.edu