GOUCHER | college

Medical Withdrawal – Request to Return Healthcare Provider Report

Purpose: This form is used when a student wishes to return to Goucher College after an official medical withdrawal, and is completed by the student's healthcare provider. "Healthcare Provider" means Licensed Healthcare Provider (e.g. MD, DO, Psychologist, Licensed Clinical Social Worker, etc.)

Student Instructions:

1. Complete Section 1 of this form – an incomplete form will not be reviewed and will be returned to you for completion.
2. Sign the form in Section 2.
3. Deliver this form to your Healthcare Provider at least six weeks prior to your planned return to the College.

Note: the Healthcare Provider must mail this form directly to the address below. It will not be accepted from the student.

Healthcare Provider Instructions:

1. Complete Sections 3 and 4 of this form.
2. Sign the form in Section 5. Note: an unsigned form will not be accepted.
3. Return the form directly to the address listed below via mail, fax or email within 4 weeks of the student's planned return to the College.

Section 1: Student Information:

Name:_____
Last First Middle Goucher ID

Mailing Address:_____
Street City State Zipcode

Phone:_____ Email address: _____

Section 2: Student Statement and signature:

I certify that the information provided above is true and correct.

Student's signature:_____Date:_____

Section 3: Licensed Healthcare Provider Information

Name:_____License Number and State:_____
Last First

Licensed as:_____Clinic/Hospital Name:_____

Mailing Address_____
Street City State Zipcode

Phone:_____Fax:_____

Section 4: Licensed Health Care Provider Report:

Please use the back of this page or attach additional documentation if you wish to expand on your responses ot the questions and/or record any other comments or observations you may wish to make regarding the student and his/her ability to function safely and successfully as a student at Goucher College.

Date of first treatment contact:_____Date of most recent treatment contact:_____

Diagnosis for which the student is being treated (i.e. description)_____

Return form to the Office of Student Support and Outreach
1021 Dulaney Valley Road, Baltmore, MD 21204
Email: Alexandra.Graves@goucher

Please provide your professional judgement in response to the following questions regarding the above named student.

☐ Yes ☐ No Has there been a substantial improvement of the student's original medical/psychological condition?

If yes, please check all of the following that you have observed a marked reduction of in this student:

☐ Number of symptoms ☐ Severity of symptoms ☐ Persistence of symptoms

☐ Functional impairment ☐ Subjective level of client distress

For how long has the improved condition been maintained?_____

What evidence has been demonstrated to suggest that the student has increased ability to manage academic life and lie independently in the residence halls.

_____

_____

What responsibilities has the student maintained during his or her time away from the college that suggests he/she is ready to return to the rigors of academic (e.g. employment, volunteerism, etc)

_____

_____

☐ Yes ☐ No ☐ Unsure In your professional judgement, do you think the student can manage a full course load (12 or more credits or 9 credits for a graduate student)?

Please elaborate on your answer:

_____

_____

What are your recommendations for continued treatment?

_____

_____

☐ Yes ☐ No Will the student have a health care provider in place in the Towson, Maryland area?

If yes, please identify the provider below:

_____

☐ Yes ☐ No Will the student have these recommendations in place at the time of potential return to campus?

Other comments:

_____

Section 5: Healthcare Provider's Signature_____Date:_____

Return form to the Office of Student Support and Outreach
1021 Dulaney Valley Road, Baltmore, MD 21204
Email: Alexandra.Graves@goucher