

Confidential Information, return ONLY to Counseling and Health*



Counseling and Health
3210 Chestnut Street
Philadelphia, PA 19104
Phone: 215.895.1402
Fax: 215.571.3518

Clinical Treatment Provider Report Form

For students requesting to return to Drexel following a medical withdrawal or medical leave from Drexel University.

INSTRUCTIONS TO THE TREATMENT PROVIDER: The patient/client named below is a student of Drexel University who has requested to return to Drexel after leaving for medical reasons. The university must receive the Clinical Treatment Provider Report Form before a medical return can be processed. All documentation must be received at least two weeks prior to the start of the term.

NOTE: This form is to be completed by a certified treatment provider and submitted to the Assistant Vice President of Student Life, Director of Counseling and Health via email to counsel@drexel.edu, fax to 215.571.3518 or mail to address above. Following review of this form, you will be contacted by OCH for information regarding next steps

If this patient believes they are entitled to accommodations and wishes to document a disability, they should contact the CZ[W`cZ8]gUV]]mF Yqci fWg at disability@drexel.edu or 215.895.1402.

Provider/Clinician Name:	Patient/Student Name:	
Provider's Professional Credentials:	License #:	State of Licensure:
Date of diagnosis of condition/symptoms resulting in request for medical withdrawal:	Date of most recent appointment:	

Diagnosis and/or symptoms:

In what way had this student's medical condition/symptoms affected their academic progress and/or ability to continue at Drexel University?

What additional assessment/treatment is recommended in order for this student to be able to resume academic progress at Drexel University?

Will you be continuing to provide treatment to this student? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, please indicate continuing treatment provider/contact information:
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Additional comments (optional):

If you wish to expand on your responses to the questions above and/or to record any other comments or observations you may wish to make regarding the student and thY]r ability to function safely, stably, and successfully as a student, please use additional pages or attach additional documentation.

ATTESTATION BY LICENSED CLINICAL TREATMENT PROVIDER:

By signing where indicated below I am representing to Drexel University that my response to each question constitutes my best professional judgment and opinion, and has been completed by me or my designee. (Student is not permitted to prepare draft for provider signature.)

Signature: _____ Date: _____

Address: _____

Phone: _____ Fax: _____

DREXEL UNIVERSITY COUNSELING AND HEALTH OFFICE USE ONLY

Notes:

***DO NOT provide this document to Academic or Faculty Advisor. If received, it will be destroyed.**