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 Reinstatement Following a Medical Leave or official withdrawal from Drexel University

INSTRUCTIONS TO THE TREATMENT PROVIDER: The patient/client named below is a student of Drexel University who has requested reinstatement after a medical withdrawal. The university must receive the Clinical Treatment Provider Report Form before a medical reinstatement 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 Assistant Vice President of Student Life, Counseling and Health via email to counsel@drexel.edu or fax to 215.571.3518.

If this patient believes they are entitled to accommodations and wishes to document a disability, they should contact the Office of Disability Resources at disability@drexel.edu or fax 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? ☐ Yes ☐ No	If no, please indicate continuing treatment provider/contact information:

Additional comments (optional):

If you wish to expand on your responses to the questions above and/or to record any other comments or observations regarding the student and their 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: _____

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Notes: