

Request for a Medical Leave of Absence: External Healthcare Provider's Recommendation Form

To the Student: Students who request a Medical Leave of Absence (MLOA) must submit the one-page MLOA Request Form directly to their academic dean, and request that their treating physician or licensed healthcare provider submit a MLOA recommendation form directly to their academic dean.

Student Name: _____ Student ID: _____ Phone: _____

Dean Name: _____ Date recommended by student: _____

To the Healthcare Provider: The requested information is needed to inform the academic dean's decision regarding whether a medical leave of absence should be granted. Please specify all of the health issues that are of concern to you and have prompted the student's request for a medical leave of absence (if multiple issues are present, please indicate in order of priority):

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Substance Use | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Limb injury |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Psychosis | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Sleep Disorder | |

Please provide the following treatment information:

Time frame of the treatment: _____ Number of sessions: _____

Type of services: _____

Brief Summary of the treatment:

Based on your assessment, do the student's health issues impair his/her academic functioning sufficiently to warrant a medical leave of absence to pursue treatment? ☐ Yes ☐ No

If so, how?

If yes, please indicate your treatment/intervention recommendation(s) for the student while he/she is away on medical leave:

- ☐ Psychotherapy with a licensed clinician, suggested frequency: _____
- ☐ Psychotropic medications prescribed and overseen by a licensed physician
- ☐ Complete a full psychiatric evaluation and follow the psychiatrist's treatment recommendations
- ☐ Enrollment in a rehabilitation program
- ☐ Enrollment in an inpatient facility
- ☐ Medical care by a licensed generalist/specialist

Comments/Other:

Please check all that apply:

- ☐ I will serve as the student's primary healthcare provider during his/her leave of absence from Duke Kunshan University.
- ☐ I have provided referrals to the student for treatment during their leave of absence.
- ☐ The student already has an identified provider.
- ☐ The student will arrange treatment with assistance from his/her family.

I am a (please check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Licensed social worker | <input type="checkbox"/> Physician (non-psychiatrist) | <input type="checkbox"/> Licensed health care provider |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Other: _____ |

Please provide your license number and state of license: _____

I have the student's written permission to communicate with you regarding their medical leave of absence and am available to consult as needed: ☐ Yes ☐ No. Please call at _____ and email _____.

Provider's signature: _____ Date: _____

Provider's printed name: _____ Affiliation: _____
(or official business stamp)