HEALTH CARE PROVIDER REPORT

Recommendations for Health Leave of Absence

Campus Support & Intervention

Office of Campus Wellbeing and Crisis Intervention

Phone: 213-740-0411

Student Instructions:

Please ask your treatment provider to complete and return to your USC Health Leave Coordinator via email or in person

Applicant's Name: _____

Applicant's Phone number: _____

Date of Birth: _____

Student ID No.: _____

Dates of leave of absence: _____

I, (student name)_____, hereby authorize the treatment provider or team named below to exchange information pertaining to my evaluation and/or treatment for the purpose of assessing my academic functioning level, safety, and readiness to return from leave.

_____

_____

_____

I understand that authorization shall remain valid from the date of my signature below and for 9 months thereafter ending on: _____

I have been informed that I may revoke this authorization by written communication to the provider named at any time. I certify that this form has been fully explained to me and that I understand its contents.

_____ _____

Signature of Client **Date of Authorization**

_____ _____

Signature of Witness **Date**

Dear Provider:

- **We are interested in obtaining information about your recommendations for this student while they are on a Health Leave of Absence.**
- **Given the rigor and challenges of the academic and social environment to which the student will return, we would like to know whether under certain conditions you feel the student will be healthy enough to continue pursuing education.**
- **It is important that we have as much information from you as is possible so we can support the student's success upon return.**
- **A Readiness to Return form must be submitted upon students request to register for classes. The student is asked to present this form at the outset of treatment after beginning the Health Leave of Absence. Providers may use their own Release of Information form in addition to the USC Campus Wellbeing and Crisis Intervention Exchange of Information form that is provided.**
- **If necessary, attach additional documentation to expand on your responses and comments regarding the student and her/his ability to function safely, stably and successfully as a full time university student.**

STUDENT NAME:_____ **DATE OF BIRTH:**_____

REASONS FOR RECOMMENDING HLOA:

TREATMENT INFORMATION

Please indicate recommended course of treatment:

TREATMENT RECOMMENDATIONS (if applicable):

Modality	Number of Sessions/Appointments	Estimated Length of Stay
Individual Therapy		
Group Therapy		
Psychiatry/Medication Management		
Individual Nutrition Counseling		
Inpatient Stabilization		
Residential		
Partial Hospitalization		
Medical Care		
Medical Testing		
Surgeries		
Rehabilitation Services/Occupational Therapy		

Other:

Please identify any other recommendations for the student while on leave (internship, work, completing required coursework):

Please identify any challenges the student may encounter in transitioning from HLOA back to the University setting. What do you recommend for support through this transition?

Additional notes or considerations (e.g. if student is International, please note whether indicated treatment would be best provided in United States or country of origin):

CLINICIAN INFORMATION (If part of a treatment program, please include name, address and phone number of facility.)

Name:_____ **License:**_____ **State:**____

Address:_____

Phone: _____

Email: _____

Signature:_____ **Date:** _____