Boston University Student Health Services 881 Commonwealth Avenue Boston, Massachusetts 02215 T 617-353-3569 F 617-353-1128



www.bu.edu/shs

## Student Report for Medical Review or Return from Medical Leave

	Student's Legal name: Preferred Name: Preferred Pronouns: Date of Birth: BU ID #:		Date Leave Taken: Semester Planning to Return: School/College: Undergrad/Grad: Grad students, month program begins:	
	•	helping us to assess the progressudies at Boston University.	ess of your recovery and your readi	ness to return
Ple	ase take some time to thin	k through your answers and att	ach additional sheets as needed.	
1.	. What were the reasons for your Leave of Absence? Please include details (mental health, physical health, etc.)			nysical health, etc.)
2.	address for all providers y	ou have seen during your LOA (	way? Please provide contact name (therapist, psychiatrist, nutritionist, ir clinician(s) to be filled out as part	, PCP, etc.) Note: You will
3.		•	ery process? How often have you be fluence you as you return to BU?	een seeing your

For	more detailed information, refer to LOA Instructions. Please contact our office to ensure all documentation is
St	tudent's Signature Date
7.	Planning for a successful return to Boston University includes academic preparation. Please tell us about any contact with your academic advisors, associate deans, whether you have finished any outstanding incompletes, etc.
6.	Please tell us why you feel you are ready to return to Boston University.
5.	We recommend continuing treatment when you return to school. Have you made efforts to identify clinicians in the Boston community if your current provider(s) cannot meet with you? If so, please include their names and contact information.
4.	Please describe how you have spent your time outside of treatment since taking your leave. Include employment, coursework, volunteer activities, etc. How has this been beneficial in your recovery?

submitted and to be advised of next steps.