



Stevens Institute of Technology

MLOA Treating Agent's Readmission Questionnaire

Instructions: This form is intended as an aid to determining a student's readiness to return from a Medical Leave of Absence (MLOA). It is to be completed only by a **licensed** individual who provided treatment during the student's leave. Please respond to the questions below and attach a statement of recommendation for readmission on your office letterhead. **This statement should describe how the treatment the student received has better prepared them to return to the stress of university life.** Send the completed form and statement to the address indicated. (If more space is needed to complete responses feel free to place responses on your letterhead and attach to this form.)

1. Full name of student: _____
2. Professional discipline for which you hold a license(s): _____
3. Did you provide the treatment for the above named student? ___ Yes ___ No
4. Has the above named student completed treatment? ___ Yes ___ No
5. When did the treatment commence? _____ Conclude? _____
6. Describe treatment: (include any hospitalization) _____

7. How many treatment sessions have you provided for the student (relating to this matter)? _____
8. Is the student presently on medication? ___ Yes ___ No
9. Indicate medication(s) and dosage(s): _____

10. In your estimation, will student need to continue medication? ___ Yes ___ No
Comments: _____

11. If the student has not completed treatment, how frequently will the client need to see you? _____

12. Have you referred the student for continuing treatment? ___ Yes ___ No.
If yes, please indicate the name, address, and phone number of the individual or agency

13. Why have you referred the student for continuing treatment (if applicable)? _____

14. If you have referred the student for continuing treatment, do you believe he/she would be able to function appropriately as a student at a University without that continued treatment? ____ Yes ____ No

15. Do you consider that the student presently, or in the reasonably foreseeable future, may be a threat to his/her own life or the lives of others? ____ Yes ____ No

Comment: _____

16. Do you think this student is able to carry a full academic load (12+ credit hours) at a University? ____ Yes ____ No

17. To your knowledge, are the parents and/or legal guardian of the student aware of the problem(s) for which you have provided treatment? ____ Yes ____ No

18. Other Comments: _____

X _____
(Signature of Treating Agent)

(Printed name of Treating Agent)

(Date)

Please remember to attach a statement of recommendation for readmission using your office letterhead. The Readmission application will not be accepted for consideration unless it includes this completed questionnaire and letter of recommendation submitted on your office letterhead. This information is confidential and will be used as an aid to make a recommendation to the Dean of Students for the purpose of readmission.

Mental Health Providers, Return to:

Director, Counseling and Psychological Services
Stevens Institute of Technology
1 Castle Point on Hudson
Hoboken, NJ 07030

Medical or Physical Health Providers, Return to:

Director, Student Health Center
Stevens Institute of Technology
1 Castle Point on Hudson
Hoboken, NJ 07030