CHECKLIST FOR STUDENTS
RETURN FROM LEAVE OF ABSENCE
(Your first step in the return process is to contact your school)

Dear Student:
The three forms attached below are required in order to evaluate your readiness to return to classes at Penn. The checklist below will guide you through the correct completion of the forms.

Please note, that forms should be faxed to CAPS: Fax (215) 573-8966

If you have any questions about the forms or about the return process, please call 215-898-7021.

Counseling and Psychological Services
University of Pennsylvania
3624 Market Street, First Floor West
Philadelphia, PA 19104
PH: (215) 898-7021

- ❑ **Obtaining Information for Leave of Absence Evaluation** (One form from each treating professional)
    1. Fill in all the information on the top of the form
    2. Fill in the students' (your) name on the blank after "I…."
    3. Fill in the name, address, and phone number of the professional who is treating you at home. (one form for each treating professional)
    4. Sign the form on the line marked "Signature of Client"
    5. Have someone who knows you sign on the line marked "Signature of Witness"
    6. Fax the form to 215-573-8966

- ❑ **Release of Information for Leave of Absence Evaluation**
    1. Fill in all the information on the top of the form
    2. Fill in the students' (your) name on the blank line after "I….".
    3. Write the name of your Advisor and School (e.g. College of Arts and Science) on the lines after the first full paragraph
    4. Sign the form on the line marked "Signature of Client".
    5. Have someone who knows you sign on the line marked "Signature of Witness"
    6. Fax the form to 215-573-8966

- ❑ **Treating Clinician, Return from Leave of Absence Information Form** (One form from each treating professional)
    1. Fill in all the information on the top of the form
    2. Give this form your treating professional (one to each professional)
    3. Advise them to **fax the form to 215-573-8966**

Counseling & Psychological Services (CAPS)
3624 Market Street
First Floor West
Philadelphia, PA 19104
(215) 898-7021, Fax (215) 573-8966

OBTAINING INFORMATION FOR LEAVE OF ABSENCE EVALUATION

Re-enrollment Application following Leave of Absence:

Name of Student: ______________________

Date of Birth: ______________________

School: ______________________

Date of Leave of Absence: _________________

I, ____________________________________, hereby authorize Counseling and Psychological Services to obtain information pertaining to my evaluation and/or counseling sessions from the person listed below for the purpose of evaluating my application to return from leave. (Name, address and phone of professional who treated or performed evaluation):

____

____

____

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 or oral communication to Counseling and Psychological Services at any time. I certify that this form has been fully explained to me and I understand its contents.

______________________________	______________________________
Signature of Client (Student)	Date of Authorization
______________________________	______________________________
Signature of Witness	Date

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University of Pennsylvania
3624 Market Street
First Floor West
Philadelphia, PA 19104
(215) 898-7021, Fax (215) 573-8966

RELEASE OF INFORMATION FOR LEAVE OF ABSENCE EVALUATION

Re-Enrollment Application following Leave of Absence:

Student's Name: ___________________________________

Date of Birth: _____________________________________

Penn ID Number: __________________________________

School: ____

Date of Leave of Absence: ___________________________

I, ________________________, hereby authorize Counseling and Psychological Services to release information pertaining to my evaluation and/or counseling sessions to the person named below for the purpose of supporting my request for a leave of absence and/or my re-enrollment.

____

____

____

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 or oral communication to Counseling and Psychological Services at any time. I certify that this form has been fully explained to me and that I understand its contents.

_________________________	_______________________________
Signature of Client (Student)	Date of Authorization
_________________________	_______________________________
Signature of Witness	Date

TREATING CLINICIAN
RETURN FROM LEAVE OF ABSENCE INFORMATION FORM

To be completed by the treating professional

Name of Student ____

Address of Student ______________________Phone _____________________

When does this student plan to return to school? _______________________________________

To which college does this student plan to return? _____________________________________

The information requested below is to assist Counseling and Psychological Services in evaluating the above named student's request to return to school following a Leave of Absence. Please attach any additional information to this form and return it to CAPS at the address below. Thank you very much.

Please FAX this form: 215.573.8966

Counseling and Psychological Services
University of Pennsylvania
3624 Market Street, First Floor West
Philadelphia, PA 19104

Attention: Return From Leave

Name: ______________________________ Credentials: ______________________

Address: ____

____

Phone: ____

Fax: ____

1. Please explain why this student engaged in treatment

2. What was your initial clinical/diagnostic impression?

3. What was the duration of your treatment?

What was the frequency of your treatment?

What was the date of your last visit?

4. Please indicate others involved in the care of this student (Name, address, phone)

   Family members:

   Other Professionals:

   Hospitals:

5. What is your current diagnostic impression?

   How stable is the student's condition?

   The environment at Penn is stressful. Please let us know your opinion about the student's ability to manage the stress successfully.

6. What medications and present doses are prescribed?

   What medications have been tried and why are they no longer being used?

7. What recommendations for further care have you made to this student now?

Can you identify any specific precipitants that could put this student at risk?

8. What additional support might benefit this student in their performance (e.g. special living situation, altered intensity of academic stress, structured activities, other campus resources, etc.?)

9. Will you continue to play a role in this student's care upon his or her return to school?

10. Please note other important observations or comments.

____ ____________________________

Signature of person completing this form Date

TREATING CLINICIAN – UPDATE FORM
RETURN FROM LEAVE OF ABSENCE INFORMATION FORM

To be completed by the treating professional - UPDATE

Name of Student ____

Address of Student ______________________________ Phone ______________________

When does this student plan to return to school? ____

To which undergraduate school does this student plan to return? __ College __Engineering __Wharton __Nursing

The **updated information** requested below is to assist Counseling and Psychological Services in evaluating the above named student's request to return to school following a leave of absence. Your comments are very useful to us.
Thank you.

TREATING CLINICIAN:

Name: ________________________________ Credentials: ______________________

Address: ____

____

Phone: ______________________________

Email: ______________________________

Fax: ______________________________

1. Since completing the initial Return from Leave Assessment, have there been any changes?

2. If so, what additional support or resources do you recommend?

Clinician's Signature: ____________________________ Date: ________________

Return (FAX) this form to:

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University of Pennsylvania
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Philadelphia, PA 19104
FAX: 215-573-8966

Attention: Return from Leave