

**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. The CAPS address:

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

If you have any questions about the forms or about the return process, please call 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. Mail the form to the address above

- **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. Mail the form to the address above

- **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 send the form to the address on the form

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

**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

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

**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

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 this form to:

Counseling and Psychological Services
University of Pennsylvania
3624 Market Street, First Floor West
Philadelphia, PA 19104
FAX: 215.573.8966

Attn: Jane E. Kotler, LCSW
Assistant Director, Clinical Administration