

TREATING HEALTHCARE PROFESSIONAL

Medical Leave of Absence Letter

This form is to be completed by the treating physician, other M.D., licensed mental health provider, or other licensed healthcare provider. Please address every question listed below by either writing a summary letter on letterhead or by completing this form (please print and write clearly if the form is completed). Signed letters or forms can be faxed or emailed to:

Academic Advising
University of Denver
303.871.3331 (fax)
303.871.2455 (phone)
advising@du.edu (email)

Please complete this form or address all of the following questions/issues in your documentation:

1. Name of the student/patient:
2. Please include the following information:
 - a. Healthcare provider's professional qualifications and licensure:
 - b. Date the student first consulted the provider:
 - c. Number of visits with the provider:
 - d. Approximate date that the provider believes the symptoms first began:
 - e. Diagnosis:
 - f. Symptoms-Please **explicitly state the functional impairments** which inhibit the student from attending classes and/or completing coursework. For instance, simply stating the student is depressed does not support a Medical Leave of Absence.
 - g. Treatment recommendations:
 - h. Estimated length of treatment plan:

Please note: If the provider has an estimation of when the student might be able to return to the University, that information can also be included in the letter.

3. Any additional information the healthcare provider thinks will be helpful for the University to know.

Provider's Signature _____ **Date:** _____