



**CERTIFICATE OF READINESS TO RETURN TO SCHOOL  
FROM A LEAVE OF ABSENCE for Medical Reasons**

**To the evaluator:** The following student left SVA for medical reasons and is now requesting to return to the School. The information that you provide will be used to determine the appropriateness of the student's return to school, as well as the type of assistance the student might need if allowed to return. Please complete this form, answering all questions, and return it with your signature. Thank you for your assistance.

Student Name \_\_\_\_\_ Student's Date of Birth \_\_\_\_\_

1. Since what date have you worked with the student? \_\_\_\_\_

2. How often have you seen the student? \_\_\_\_\_

3. Describe the student's impairment at the beginning of their treatment (please specify symptoms and include diagnosis):

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4. Explain the current status of the impairment:

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5. Explain specific conditions or circumstances which may exacerbate the condition:

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6. What is the current treatment plan (include follow-up psychotherapy and medication management by psychiatrist):

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7. Given the student's level of functioning and the treatment plan:

a. What difficulties do you anticipate for the student in performing academically, fitting in within the school community, or having a recurrence of symptoms?

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b. Is this student able to return to school? If so, do you recommend full-time or part-time status? Please note, if part-time is recommended, student will have to seek approval of this through the Disability Services Office.

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c. Is this student appropriate to live in a university residence?

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8. Please include any additional information:

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Name, Professional Degree, and Licensure/Certification:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Student:**

I have reviewed the completed form and approve the release of information to SVA. I also understand that I am responsible for initiating/continuing the treatment recommended by my health care provider.

**Student signature and date:** \_\_\_\_\_