



**Medical Leave of Absence, Health Care Provider Form**

*Instructions: This form is to be completed by the student's community health provider and be mailed to: Student Health and Counseling, Attention: Amy Gonzalez, 1 College Circle, Geneseo NY, 14454 or faxed to 585-245-5744.*

Student name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Provider name: \_\_\_\_\_ License #: \_\_\_\_\_

Provider licensed as: \_\_\_\_\_ State of licensure: \_\_\_\_\_

ICD-10 diagnoses Related to Leave: \_\_\_\_\_

Dates of treatment (first session and most recent): \_\_\_\_\_

Planned treatments (e.g., surgery, hospitalizations, medications, rehabilitation):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other relevant clinical issues: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Anticipated course of treatment and planned return to academics:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Clinician signature: \_\_\_\_\_ Date: \_\_\_\_\_

2/2025