University of Portland
5000 N Willamette Blvd.
Portland, OR, 97203
www.up.edu

University of Portland

Reenrollment Questionnaire in Support of Return from Medical Leave of Absence

STUDENT NAME: ______________________________________ DATE: __________________

STUDENT D.O.B.: ____________________ STUDENT ID NUMBER: _____________________

TO BE COMPLETED ONLY BY A LICENSED HEALTH PROFESSIONAL

Dear Provider,

Decisions to allow a student to reenroll following a medical leave of absence are made after carefully considering all pertinent information, including an evaluation of the student by an appropriately qualified health or mental health professional. The final decision to allow a student to reenroll will be made solely by the University of Portland based on all available information.

When assessing a student for their ability to return to the University of Portland for the continuation of studies, please be aware that the student will be returning to a community that is designed to challenge students through a rigorous course of study and, if the student intends to live on campus, an intentional residential community. **Please provide as much information as you believe may be helpful for the University to consider in determining whether the student is prepared to reenter University life successfully.** If you would like more information about the University community or believe that specific information about the student's course of study may aid you in your evaluation, please contact the University of Portland at associateprovost@up.edu or by fax at 503-943-7401.

If you believe assistance may be necessary to allow the student to return to a full course of study (12 credit hours), manage the accompanying study workload (generally a minimum of two hours of study per week for every registered credit hour), and participate fully in a residential community, please indicate such in question 9 on page 3.

If more space is needed to answer any questions below, please attach a separate page to this document if necessary.

1. Reason for medical leave:

2. Date medical leave began: ______________

3. Your Profession: ___ Psychiatrist
   ___ Psychologist, LPC, LCSW, LMFT
   ___ Physician, Specialty: ___________________________________
   ___ NP, PMHNP
   ___ Other, Please describe: ___________________________________

4. First/ Last Day of treatment and treatment frequency:

5. Provide a brief description of the treatment provided to this student for this condition since _________ [start date of medical leave]:

6. Describe the student’s capacity to reenroll and fully engage in the activities associated with studying in a university setting:

7. After meeting with the student as described above and reviewing any relevant programmatic information, my opinion about the student’s readiness to resume University study is:

8. What are the treatment recommendations and supports you believe the student will need to be successful?

___ I recommend that this student return to the University of Portland at this time.

___ I do not recommend that this student return to the University of Portland at this time.

9. Explain your selection in the box above regarding your recommendation for the student to return:

HEALTH PROFESSIONAL

NAME (PRINT): ____ DATE: ____________________

TITLE/POSITION: ____

LICENSE #: ____

SIGNATURE: ____

ADDRESS: ____

PHONE NUMBER: ____

Thank you for your help in evaluating this student's request for reenrollment at the University of Portland.

Please return this form via email (preferred) or fax to:
University of Portland
Student Wellness Center
Care Team
Email: careteam@up.edu
Phone: 503-943-7134
Fax: 503-943-7199