XAVIER UNIVERSITY
PROVIDER TREATMENT FORM

Dear Provider: You have been asked to complete this form as part of the process by which students returning from a Leave of Absence from Xavier are transitioned back into the University community.

We want to ensure the student is able to participate in Xavier's community by providing the student access to the most helpful supports and resources, including a referral to Accessibility and Disability Services for reasonable accommodations, if needed. Please contact the Dean of Students (deanofstudents@xavier.edu) if you have any questions or concerns. This form will be uploaded by the student.

Part 1: TO BE COMPLETED BY STUDENT

Name: _____ Today's Date: _____

Xavier ID: _____ Date of Birth: _____

Date of leave: _____ Anticipated Return Term: _____

Undergraduate College/Graduate Department: _____

Provider(s): _____

I hereby authorize my Provider(s) to release treatment records and related information as requested/described in this release to Xavier University, Dean of Students Office. I further request and authorize my Provider to provide treatment information and responses to the questions listed on this form and/or have oral communications with the Xavier University Dean of Students for the purpose of my reinstatement and transition to being a Xavier student. I understand that the treatment records could include, but are not limited to information concerning drug abuse or drug related conditions, alcoholism, psychological, and psychiatric conditions, provided that such release is limited specifically to material of the nature and extent described herein.

Date(s) of Treatment: _____

Specific information requested:

☐Case summary ☐Psychological testing reports

☐Diagnosis(es) ☐Medications and dosages

☐Types of service ☐Other:

I understand that the information used and/or disclosed pursuant to this release authorization will be confidential at Xavier University under the Family Educational Rights and Privacy Act (FERPA).

I understand that this authorization is voluntary and I may refuse to sign. This authorization will expire in 180 days from the date on which I sign it. I understand that I may revoke this authorization at any time by providing written notice to the Dean of Students Office.

Signature: _____ Date: _____

PART 2:TO BE COMPLETED BY THE TREATMENT PROVIDER

Name of Provider: _____ Credentials: _____

Address: _____ Telephone: _____

_____ Fax: _____

_____ Email: _____

1. Please describe the date(s) (i.e., beginning and end of treatment, and frequency) and type (s) of treatment provided.

2. Please complete subpart (a) through (c).
   a. Do you have concerns about the student's capacity to carry out substantial self-care obligations (e.g., attending to activities of daily living)?
      - ☐ No concerns
      - ☐ Minor concerns
      - ☐ Moderate concerns
      - ☐ Student is unable or unwilling to carry out substantial self-care obligations

   If you have indicated moderate concerns or believe the student is unable or unwilling to carry out substantial self-care obligations, please explain below, including recommendation on mitigating such concerns:

   b. Do you have concerns about the student as it pertains to their personal safety?
      - ☐ No concerns
      - ☐ Minor concerns
      - ☐ Moderate concerns
      - ☐ Student is unable or unwilling to carry out substantial self-care obligations

   If you have indicated moderate concerns or believe the student is unable or unwilling to carry out substantial self-care obligations, please explain below, including recommendation on mitigating such concerns:

3. Please tell us if continuing treatment is recommended upon return to academics and community living (specify the type, frequency and duration of care you recommend, and the symptoms or functional difficulties that on-going treatment may need to address)

Signature if Treatment Provider: _____ Date: _____
Name and Credentials of Provider: _____
Agency/Organization_____