Governors State UNIVERSITY

Office of the Dean of Students
University Park, IL 60484
Room C1310
708.235.7595
deanofstudents@govst.edu
www.govst.edu/studentaffairs
www.govst.edu/DOS

Emergency/Medical Leave Healthcare Provider Form

This form must be completed in full. Any blank spaces may lead to a delay in processing the request. Please type or print clearly in ink.

Section 1: Student Information (to be completed by student)

Student Name: _____ Date of Birth: _____ Student ID#: _____

Permanent Street Address: _____

Phone: _____ GSU student email: _____

Term (Fall, Spring, Summer) & Year for which you are requesting an Emergency/Medical Leave: _____

I understand and consent to the following: The information below will be reviewed by the Office of the Dean of Students. I also understand that the Dean of Students may share this information with other GSU officials, as necessary, for the purpose of review of the Emergency/Medical Leave request.

Signature: _____ Date: _____

Section 2: Healthcare Provider Information (to be completed by healthcare provider)

The above named student has requested an Emergency/Medical Leave from Governors State University, stating they had a significant condition that prevented them from meeting the expectations of a student during the indicated term. An Emergency/Medical Leave is a request to drop all courses for the stated semester. The student reports that you evaluated or treated them for that condition during that time period. Please complete in its entirety the following information regarding that condition, sign, and forward to the Office of the Dean of Students at the address noted.

Provider's Name: _____ Provider's Title / Degree: _____

Provider's Area of Medical / Mental Health Specialization: _____

Office Name & Address: _____

Phone: _____ Fax: _____ Email: _____

Assessment & Treatment:

Date(s) of treatment / assessment: _____ to _____

Diagnoses related to the concerns of this request: _____

_____

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Was this patient hospitalized for this condition? Yes No If yes, dates of hospitalization: _____

Status during the time period of the requested leave: Acute / critical Chronic / recurrent

Duration of the condition (period of time during which the student was unable to meet expectations as a student)_____

_____

How did the condition affect the student's ability to attend classes, complete work, etc.?_____

_____

_____

Recommendation:

Do you believe that the student, due to the condition(s) described above, was unable to meet the expectations of a student during the time period of the requested Emergency/Medical Leave? Please elaborate or include additional documentation as necessary. Yes No

Please explain:_____

_____

_____

Do you support the granting of Emergency/Medical Leave for the requested academic term? Yes No

Please explain:_____

_____

_____

Signature of the provider: _____Date:_____

(A business card may also be attached to this submission)

Please complete in full and submit to:

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1 University Parkway, Room C1310
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Phone: 708.235.7595
Email: deanofstudents@govst.edu
Fax: 708.235.3961