



Leave of Absence Supplemental Information Form: Leave for Health Condition

Students: Please complete the top section and ask your health care or mental health treatment provider to complete and submit the form. Before resuming your studies, please complete and submit the [Return from a Leave of Absence](#) form. In addition, please ask your provider to sign the last section of this form in order to support your resumption of academic activities. Please send questions to gs-counselor@umd.edu.

Student's Full Name (Last, First, Middle)

Student ID Number

Today's Date

Health Care or Mental Health Treatment Provider

Name of Provider

Type of Practice/Specialty

Title/Degree

Street Address of Practice

City, State & Zip Code

Telephone

Licensing Board

License Number

Email

In Support of a Leave of Absence

Please indicate the length of time you are recommending for the student to take the leave of absence.

One semester

Two semesters

Will you be providing care to the student while they are on their leave of absence?

Yes

No

Does the student need any assistance coordinating treatment, such as finding a provider, transferring prescriptions, or reviewing insurance coverage, etc.?

Yes

No

By signing below, I affirm the above information to be true and valid and that the student has a health condition requiring a leave of absence from graduate study.

Provider's Signature

Date

In Support of a Return from Leave of Absence

By signing below, I affirm that the student is medically cleared to return to academic activities.

Provider's Signature

Date