



Leave of Absence Supplemental Information Form:
Leave for Health Condition

Students: Please complete the top section of this form and ask your health care provider and/or mental health treatment provider to complete and submit the form.

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

Student ID Number

Today's Date

Health Care Providers: Please direct questions to gs-counselor@umd.edu

Name of Health Care/Mental Health Provider

Type of Practice/Specialty

Title/Degree

Type of Practice/Specialty

Health Care Provider's Address

Telephone

Email

License Number

Licensing Board

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, reviewing insurance coverage, etc.?

Yes

No

Health Care Provider's Signature

Date