Directions for Students Taking Medical Leave for Psychological Reasons

The enclosed cover letter, questionnaire, and FERPA authorization are to be used for WFU Wake Forest University students who are taking a medical withdrawal that includes psychological reasons. As a part of this type of leave from the university, students are expected to address the psychological condition(s) which necessitated the absence. This includes engaging a licensed mental health professional as a part of the care for these issues. Students will need to complete the attached FERPA Authorization for your provider prior to giving them this form. It is then recommended that the enclosed documentation is provided to a licensed mental health provider at the beginning of a student’s treatment so that they understand what information needed from them. Undergraduate students should contact the Office of Academic Advising with any questions related to a leave from the university, while students from Wake Forest University graduate and professional schools should contact relevant administrators.
WAKE FOREST UNIVERSITY

AUTHORIZATION FOR DISCLOSURE OF INFORMATION
IN EDUCATION RECORDS

The Family Educational Rights and Privacy Act of 1974 (FERPA) provides certain rights and protections to students regarding the disclosure of their education records maintained by the University. These education records include files, documents and materials in whatever medium which contain information directly related to a student and from which a student can be individually identified.

By signing this Authorization, you hereby authorize Wake Forest University, acting through its employees and/or agents, to disclose the following information from your education record:

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

The above information from your education records will be disclosed to the following individual(s) or class of individuals for the purpose(s) specified:

Please specify the name(s) of individual(s) or the class of individuals who are authorized to receive information from the education record and the purpose for the disclosure:

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

This Authorization may be revoked at any time by submitting a written revocation to _______________________. Such revocation will not affect disclosures made prior to receipt of the written revocation. Unless earlier revoked, this Authorization will remain in effect for the 20__-20__ academic year.

I hereby voluntarily authorization Wake Forest University to disclose the above specified information from my education records to the individual(s) designated herein. I understand that I may request a copy of the records disclosed.

_________________________________________  __________________________
Signature of Student                      Date
Dear Licensed Mental Health Professional,

Your client/patient has taken a medical leave of absence for psychological reasons from Wake Forest University. When this student is interested in returning to Wake Forest University to pursue his/her education, the student must provide verification from a licensed mental health professional that:

- she/he has followed through with a course of treatment appropriate to the condition(s) which necessitated her/his departure from the university,
- his/her condition has improved for a sufficient period of time, and
- she/he is ready to resume full-time student status.

To help facilitate this process, please complete and return the following to the Wake Forest University Counseling Center:

- Licensed Mental Health Professional Reenrollment Questionnaire (enclosed)
- A brief treatment summary on office letterhead with your professional opinion about whether the student is ready to resume full-time study at Wake Forest University

Additionally, to facilitate this process please obtain a release of information, signed by the student, which will permit you to communicate with any senior staff member of the Wake Forest University Counseling Center regarding the student’s course of treatment and recommendations, if any, for continued care. Our communication with you in this matter will be essential in the reenrollment consideration process for the student.

We appreciate your help. If you have any questions, please feel free to call the Wake Forest University Counseling Center at (336) 758-5273.

Warmly,

[Signature]

James D. Raper, PhD, LPC-S
Director
Readmission Questionnaire for Medical/Psychological Withdrawal

Instructions: This form is to be completed by a Licensed Mental Health Professional. Please respond to all of the questions listed below and attach a treatment summary – which includes a statement of recommendation – on your office letterhead.

Full name of student: ______________________________________________________

Please check the discipline(s) in which you have an active license:
Psychiatry ☐  Psychology ☐  Professional Counseling ☐
Clinical Social Work ☐  Marriage and Family Therapy ☐
Other ☐ __________________

Did you provide treatment for the above named student? Yes ☐  No ☐

To date, how many treatment sessions have you provided for the student related to the reason for their medical/psychological withdrawal? __________________

Please indicate any specific treatment program the student participated in while on leave (e.g., Outpatient therapy, Partial hospitalization, Inpatient hospitalization, etc.)
____________________________________________________________________________
                                                                                   
____________________________________________________________________________
                                                                                   
____________________________________________________________________________

Has the above student successfully completed treatment? Yes ☐  No ☐

On what date did the treatment commence? __________________

On what date did the treatment conclude? __________________

If the student has not completed treatment, describe the ongoing treatment plan under your care:
____________________________________________________________________________
                                                                                   
____________________________________________________________________________
At any point during your treatment of the student did he/she receive a prescription for, and/or take medication related to mental health issues (please indicate even if you are not the prescribing physician)? Yes ☐ No ☐

If yes, please indicate medication(s), dosage, and schedule: _____________________________

_____________________________________________________________________________

Is it recommended that the student remain on these medications if she/he were to return to Wake Forest University? Yes ☐ No ☐

If yes, what is the plan for medication management? ________________________________

_____________________________________________________________________________

Have you referred the student for continued treatment to another provider or agency appropriate for their concerns? Yes ☐ No ☐

If yes, please indicate the name, address, and phone number of the provider and/or agency:

_____________________________________________________________________________

_____________________________________________________________________________

What are the continued care needs for this student? ________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

While in your care were there any increased risk-related concerns (e.g., suicide, homicide, self-injury, psychosis, alcohol/other drug use, etc.)? Yes (If Yes, please elaborate below) ☐ No ☐

To your knowledge, are the parents and/or legal guardian(s) of the student aware of the problem(s) for which you have provided treatment? Yes ☐ No ☐
In your professional opinion, is the student ready to return as a full-time student and take on the academic, social, residential, and other demands of student life? Yes [ ] No [ ]

Please explain the reason(s) for your answer in the statement to be submitted with this questionnaire.

Other comments to assist with the student’s successful transition to Wake Forest University:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Signature of Provider _________________________ Date _________________________

Name of Provider (please print/type) _________________________ Phone Number _________________________

Address of Provider _______________________________________________________________________

Please remember to attach a brief statement of your professional opinion regarding readiness for reenrollment on your office letterhead as well as a treatment summary.

Return to:
University Counseling Center
Wake Forest University
Box 7838
Winston-Salem, NC 27109

Fax: 336-758-1991

Completion of this documentation does not guarantee the student readmission to the university, but is a requirement for consideration.