TREATING DOCTOR or LICENSED MENTAL HEALTH PROFESSIONAL
ASSESSMENT OR RE-ENROLLMENT QUESTIONNAIRE

Instructions: This questionnaire is to be completed only by the treating physician, psychiatrist, licensed psychologist, or medical or other appropriate mental health professional. Please respond to the questions listed below and send the following to the address included at the end of this questionnaire:

On occasion a student requests to take a leave of absence and is subsequently held from re-enrollment at Florida Atlantic University for medical/psychological reasons. This procedure is employed only after all available University resources have been pursued in an attempt to reduce or remedy the student’s medical/psychological issues and/or behaviors. The University reserves the right to determine whether the student, under certain conditions, may remain enrolled during any particular semester. A decision to administratively hold a student from re-enrollment for medical/psychological reasons is made only after consideration of all pertinent information and appropriate consultation with physicians, psychiatrists, psychologists, and/or other licensed health professionals. Therefore, it is the policy of Florida Atlantic University that any student administratively held from re-enrollment for medical/psychological reasons must have this form completed by a licensed physician or mental health professional and submitted to the University for approval before the student will be permitted to re-enroll.

If the issue and/or behavior is/are medical, a physician (or ARNP or PA) must complete the form. If the issue is behavioral and/or psychological, a psychiatrist, licensed psychologist or other appropriate, licensed mental health professional must complete the form. If a student seeks an evaluation from a community mental health clinic, it is understood that she or he may be seen by psychologists or social workers with the option of being evaluated by a psychiatrist for medication or further diagnosis. If the student has been hospitalized, personnel on the hospital treatment team may appropriately complete this questionnaire.

1. Full name of student: ___________________________ Z#___________________

2. a. Are you a licensed _____ physician/ARNP/PA, or _____ psychiatrist, or _____ psychologist ______ other (list degree and title) ________________
   b. Did you provide the treatment for the above named student? _____Yes _____No

3. Briefly describe the student’s medical or psychiatric symptoms that required a leave of absence. Attach a separate page if necessary.

   ________________________________________________________________

4. Have you referred the student for continuing treatment? _____Yes _____No

   If Yes, please indicate the name, address, and phone number of the individual or agency. For mental health treatment, you may wish to consult with FAU Counseling and Psychological Services (CAPS) personnel regarding the availability and appropriateness of referral resources in the community. Please keep in mind
that FAU Counseling and Psychological Services operates on a short-term model treating moderate levels of psychopathology, and that a referral to FAU CAPS for long-term intensive psychotherapy is inappropriate for the student.

5. Do you consider the student presently to be harmful to others?
   _____Yes       _____No
   __________________________________________________________________________

6. In your professional opinion, is the student medically and/or psychologically fit to return to school (i.e. the student is able to assume full academic responsibilities)?
   _____Yes       _____No
   Comments: ____________________________________________________________________
   __________________________________________________________________________

7. Other considerations regarding recommendation for re-enrollment
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

Name of Treating Professional (Please Print)     Signature of Treating Professional     Date

Please stamp with office stamp or write license number here (required): ____________________________

Please return this form to the student for submission, fax the form to 561-297-2502, or mail to the following address:
Dean of Students Florida Atlantic University
Bldg. 8, Room 226
777 Glades Road
Boca Raton, FL 33431

Revised 7/7/17