Request for Permission to Re-enroll following a Voluntary Medical Leave of Absence

(To be completed by a student seeking to re-enroll following a Voluntary Medical Leave of Absence (MLOA) and submitted with the materials referred to below to the student's Primary Health Liaison).

Student Statement and Request:

1. This request for permission to re-enroll is for (check one):

   ☐ Spring semester (*this form must be submitted by* **November 1** *prior to the upcoming spring semester*)

   ☐ Summer session(s) (*this form must be submitted by* **April 1** *prior to the upcoming summer session*)

   ☐ Fall semester (*this form must be submitted by* **June 1** *prior to the upcoming fall semester*)

2. I have contacted my Associate Dean and have made arrangements to compete any unfinished course work prior to returning from my MLOA.

3. I understand the Associate Dean, the Dean of Students, any my Primary Health Liaison (collectively "Re-enrollment Committee") will consider my request for re-enrollment. If I am requesting re-enrollment in a school or college other than the one in which I was most recently enrolled, I understand the Associate Dean of that school or college will also be included as a part of the Re-enrollment Committee.

4. I am enclosing a re-enrollment form that has been completed and signed by my licensed health care provider documenting my treatment since the commencement of my MLOA, my clinical status, and his or her opinion as to my readiness to successfully resume academics and University life at Drake University.

5. I have also provided my licensed health care provider with a signed patient's waiver authorizing him or her to discuss my request for re-enrollment with my Primary Health Liaison and to provide any relevant medical records, facts, opinions and recommendations pertaining to my request.

6. I authorize the members of the re-enrollment committee to discuss my request for re-enrollment along with any other information I provide in connection with my request for re-enrollment and the information provided by my licensed health care provider in considering my request for re-enrollment. I have authorized my Primary Health Liaison to communicate with my licensed health care provider and, where deemed appropriate, I authorize my Primary Health Liaison to communicate with the University's Disability Resources and/or Office of Academic Assistance regarding my request for re-enrollment and return to the University.

7. ☐ I have been asked to provide and I am enclosing a brief statement in accordance with paragraph 4 of the University's MLOA Policy pertaining to "Requesting Permission to Re-enroll following a MLOA". *(check and provide statement, only if previously requested)*.

____

(*Student's signature*)

____

(*Student's printed name*)

____

Date

Licensed Health Care Provider (Form Pertaining to Request for Re-enrollment)

(This form is to be completed by a current licensed health care provider of a student who is on a voluntary medical leave of absence and is seeking re-enrollment at Drake University)

1. I________________________[*health care provider's name*] am a health care provider licensed in the state(s) of_______________________________.

2. ________________ [*Student/Patient/Client's name*] is currently under my care and the following information is provided with respect him/her.

3. Brief description of the treatment provided since_____________[*date of commencement of voluntary medical leave of absence from Drake University*].

   ____
   ____
   ____
   ____

4. Clinical status at this time: ____

5. The following is my opinion as to the above Student/Patient/Client's readiness to resume academics and University life at Drake University.

   ____
   ____
   ____

6. In providing the above opinion I reviewed and took into consideration the information contained in following documents which set forth certain specific program requirements which I understand it is necessary to be able to successfully meet within the Student/Patient/Client's particular educational program at the University (include title of document(s) or if none have been provided answer "NA"):

   ____
   ____

7. The Student/Patient/Client has provided me with a signed patient's waiver authorizing me to discuss his/her request for re-enrollment at Drake University with certain University officials.

____
[*Signature of Licensed Health Care Provider]*

____
[*Printed Name of Licensed Health Care Provider*]

____
Date

Authorization for Release of Medical/Psychological Information to Drake University

(pertaining to re-enrollment)

I am currently on a medical leave of absence from Drake University because I was experiencing a health issue that was significantly impacting my academic and or university life. I have requested the opportunity to re-enroll and in order to consider my request the University will require certain relevant medical/psychological records, facts, opinions and recommendations from you. Therefore, I voluntarily authorize the direct ______________________________ ______________________________ to complete the attached form and to further release any relevant medical records, facts, opinions and recommendations that pertaining to my request for re-enrollment to:

(Check one of the following)

☐ Associate Dean
Drake University
College of ____________________
____
____

☐ Drake University Counseling Center
3116 Carpenter Ave
Des Moines, Ia 50311
(515)271-3864

☐ Student Health Center

3116 Carpenter Ave
Des Moines, IA 50311

I understand this disclosure may include any or all of the following information:

1. Oral and /or written disclosure of counselor/therapist/health care provider notes, and/or records as a result of any medical exams, evaluations, and therapy/counseling sessions.
2. The results of any medical and psychological tests performed.
3. Any progress notes.
4. Any history obtained
5. Other

I understand the information to be released may include information in the following categories unless I specifically indicate that should not be released by checking below:

(INITIAL ANY CATEGORY NOT TO BE RELEASED)

Substance Abuse__________ Mental Health____________ HIV-Related Info _________

This authorization is effective for months, but no longer than one year from the date of my signature below. I understand I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the name and address I have checked above.

I certify that any person(s) who may furnish any information disclosed pursuant to this Authorization for Release of Medical/Psychological Information to Drake (“Authorization”) shall not be held accountable for releasing or disclosing such information, and I hereby release said person(s) from any and all liability for damage of whatever kind which may at any time result to me, my heirs, and my family and my associates because of compliance with this Authorization.

I further release Drake University from any and all liability for damage of whatever kind which may at result to me, my heirs, my family and my associates because of information it receives pursuant to this Authorization.

Signature of Patient/Client or Legal Representative:______________________________Date:
____

Relationship to Patient/Client if signed by Legal Representative:
____

Prohibition of Redisclosure: This form does not authorize redisclosure of information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific consent of the patient/client, or as otherwise permitted by such law and/or regulations. A general authorization for the release of information is NOT sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.