



# Certification of Readiness to Return to School from Medical Leave of Absence

## GOING ON LEAVE

- 1) Schedule an interview with \_\_\_\_\_. This evaluation will be passed along to your school as part of the decision whether to place you on medical leave.
- 2) After the evaluation, make an appointment with \_\_\_\_\_, who will confirm whether you've been placed on leave and, if so, handle paperwork, explain about refunds, and answer other questions.
- 3) If you live on campus, talk to the Residence Hall Director of your building about leaving your room and getting a refund.
- 4) To find out if you still will have NYU-CHP insurance coverage, you may call (212) 443-1020.

## RETURNING FROM LEAVE

- 1) If you are placed on voluntary medical leave, it is expected that you leave school for a full semester or the equivalent in months (4 months). Except in very rare circumstances, one or two months is not enough time to be on leave.
- 2) If you are placed on an involuntary medical leave, it is required that you be on leave from school for the remainder of the semester during which the leave was mandated AND the following full semester.
- 3) You must pursue and be engaged in appropriate treatment for the duration of your time on leave from NYU.
- 4) One month before you wish to return to school (December for the spring term; May for the summer; August for the fall), ask your therapist to fill out in its entirety the *Certificate of Readiness to Return to School* form. Fax (212-995-4096) or address the letter to:

\_\_\_\_\_ (Your CWS Evaluator)  
 NYU Student Health Center  
 Counseling and Wellness Services  
 726 Broadway, Suite 471  
 New York, NY 10003

- 5) Also, one month before you wish to return to school, call 212-998-4780 to schedule a *Return from Medical Leave* interview with \_\_\_\_\_. **You must fax or mail the completed *Certificate of Readiness* to the office prior to the scheduled interview time.**
- 6) Based on your therapist's letter and the Counseling and Wellness Services interview, CWS will make a recommendation to the school about your readiness to return. The school dean will then inform you of the final decision.
- 7) In case your request to return from medical leave is denied, you are eligible to reapply for return from leave the next semester, following the same steps #3-6.
- 8) If you wish to extend your medical leave, contact \_\_\_\_\_ from your school.



# Certification of Readiness to Return to School from Medical Leave of Absence

**To the evaluator:** The student named below has requested to return from a medical leave. The information you provide will be used to determine the appropriateness of the student's return to school. A signed release is attached to this form. Please complete this form, answering all questions, and return it with your signature and the student's signature providing release of information. Thank you for your assistance.A

Today's Date: \_\_\_/\_\_\_/\_\_\_

Student's Name: \_\_\_\_\_ Student's Date of Birth: \_\_\_/\_\_\_/\_\_\_

1. Date you began working with the student: \_\_\_/\_\_\_/\_\_\_

2. How often have you seen the student? \_\_\_\_\_

3. Describe the student's impairment at the beginning of the medical leave (please specify symptoms and include diagnosis).

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4. Explain the current status of the impairment and of the original symptoms.

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5. Explain specific conditions or circumstances which may exacerbate the condition.

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PLEASE COMPLETE REVERSE SIDE ►

6. What is the current treatment plan (include follow-up psychotherapy and medication management, if any)?

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7. Given the student's current level of functioning and the treatment plan:

a. What difficulties do you anticipate for the student in performing academically, fitting in within the university community, or having a recurrence of symptoms?

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b. Is this student able to return to school? If so, do you recommend full-time or part-time status?

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c. Is this student appropriate to live in a university residence? \_\_\_\_\_

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8. Please include any additional information:

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Name: _____
Professional Degree: _____
Licensure/Certification: _____
Address: _____ Telephone: _____
Signature: _____

\_\_\_\_\_  
Student's signature providing release of information

\_\_\_\_\_  
Date

Return to:  
NYU Student Health Center • Counseling and Wellness Services  
726 Broadway, Suite 471, New York, NY 10003

Or fax to **212-995-4096**