

**Medical Provider Report**

This form must be completed by the student’s provider. It provides assurance that the student followed through with treatment and is ready to return to school. This form must be mailed to the Dean of Students by the provider directly to:

Division of Student Affairs/Dean of Students

Anne E. Fisher, Ph.D.

New College of Florida

5800 Bay Shore Road

Sarasota, FL 34243

Phone: (941) 487-4250 Fax: (941) 487-4517

**Provider Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Student Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Licensed as**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of first treatment**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Licensure State and #**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of most recent treatment**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial ICD 10 Dx**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current ICD 10 Dx**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**: (please include dose, length of time on medication and length of time student has been stabilized on current dose)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please provide your professional judgment in response to the following questions regarding the student named above. Check “yes” or “no.”

**⃝ YES** or ⃝ **NO** There has been a substantial amelioration of the student’s original medical condition.

If “**yes**,” please check all the following that you have observed a marked reduction of in this student:

⃝ Number of symptoms ⃝ Severity of symptoms ⃝ Persistence of Symptoms

⃝ Functional impairment ⃝ Subjective level of distress

Please provide a brief narrative indicating the degree to which issues have been resolved and the student’s ability to function and to be successful as a full time student at this time. If however, the student is not yet ready to return, please state that here, as well as a projected plan for return to college.

Please list any recommendations for continued care including treatment, academics, ability to live independently and participate in residential life in the residence halls, social skills, etc.

Will the student continue to seek treatment with you? ⃝ YES ⃝ NO ⃝ N/A

(If “no,” please provide contact information of the professional to whom the student was referred here.)

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Provider Signature Date

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_