Saint Mary's College of California
REQUEST FOR MEDICAL/PSYCHOLOGICAL DOCUMENTATION
Office of the Assistant Vice Provost for Student Success

MEDICAL/MENTAL HEALTH PROVIDER -- PLEASE RETURN COMPLETED FORM DIRECTLY TO:
Academic Probation Review Board via email to aprb@stmarys-ca.edu

PART I. TO BE COMPLETED BY THE STUDENT:

I hereby authorize the release of all information with respect to my physical or mental health as requested on this document. I further authorize the health care provider named on this form to discuss confidential medical or mental health related information with the Assistant Vice Provost for Student Success.

_____ _____ _____ _____
Student's Last Name (please print) **First Name** **M.I.** **SMC Student ID #**

_____ _____
Student's Signature **Date**

Parts II and III to be completed by the student's treating, licensed, non-familial, health care professional

PART II.

CERTIFYING PROFESSIONAL AND TITLE: (please print)	**LICENSE #:**

DIAGNOSIS AND RELEVANT SYMPTOMS:

_____

_____

HISTORY AND PROGNOSIS: MM / DD / YYYY

1. Date condition(s) was first diagnosed by a licensed health care professional: _____/_____/_____
2. Date student first visited you for this condition(s): _____/_____/_____
3. Date student was most recently treated by you for this condition(s): _____/_____/_____
4. Expected duration of condition(s): _____
5. Have you prescribed or recommended that the student stop attending classes? ☐ NO ☐ YES Date: _____/_____/_____

CURRENT TREATMENT PLAN:

_____

_____

ASSESSMENT OF LIMITATIONS OR AFFECTS CONDITION MAY HAVE (OR HAD) RELATED TO A COLLEGE ENVIRONMENT:

_____

_____

_____

Continued Student/Patient:_____

PART III. PLEASE INDICATE THE IMPACT OF THE CONDITION AND/ITS TREATMENT ON THE FOLLOWING:

	N / A	MODERATE IMPACT	SEVERE IMPACT	DESCRIPTION OF IMPACT IF MODERATE OR SEVERE
Treatment / Medication Side Effects	☐	☐	☐	
Pain	☐	☐	☐	
Walking / Standing / Sitting	☐	☐	☐	*Include distance / duration / assistive devices*
Performing Manual Tasks i.e. writing, keyboarding	☐	☐	☐	*Include duration*
Breathing	☐	☐	☐	
Hearing / Vision	☐	☐	☐	
Sleeping	☐	☐	☐	
Delusions / Hallucinations	☐	☐	☐	
Obsessions / Compulsions	☐	☐	☐	
Mood / Emotional Regulation	☐	☐	☐	
Hyperactivity / Impulsivity	☐	☐	☐	
Organization / Executive Functioning	☐	☐	☐	
Concentration / Sustained Focus	☐	☐	☐	
Memory	☐	☐	☐	
Thinking / Learning	☐	☐	☐	
Social Skills / Interactions	☐	☐	☐	
Verbal Communication / Speech	☐	☐	☐	

CERTIFYING PROFESSIONAL'S SIGNATURE: _____ **DATE**_____

PRACTICE NAME: _____

STREET ADDRESS: _____ CITY, STATE, ZIP/POSTAL _____

TELEPHONE NUMBER_____ FAX NUMBER_____

SUBMIT