OFFICE OF THE VICE PRESIDENT FOR STUDENT AFFAIRS AND ENROLLMENT MANAGEMENT
JACKSONVILLE STATE UNIVERSITY

Licensed Provider Recommendation for Return to Campus

Provider: _____ Phone: _____

Address: _____ City: _____ State: _____

Provider Credentials. **Mark all that apply:** ☐ **MD** ☐ **DO** ☐ **DNP**

☐ **Mental Health Professional** Please specify: _____

NPI #: _____ License Number: _____State of Issue: _____

Patient's Full Name: _____

Patient's Date of Birth: _____

Patient's Diagnoses with ICD-10 and/or DSM Codes: _____

_____

_____

Describe how the patient's condition has resolved or stabilized so that it is not likely to interfere with the patient's academic performance, safety or wellbeing at Jacksonville State University?

_____
_____
_____
_____
_____

Will the patient need reasonable accommodations to fully participate in the university setting? (e.g., academic, housing, meal plan.)

_____

With my signature below, I provide my recommendation for the patient to return to campus for the _____term or semester, 20_____. The patient has given me permission to share the foregoing information with Jacksonville State University officials.

Signature: _____ Date: _____

Stamp: _____

III:13

700 Pelham Road North
Jacksonville, AL 36265-1602
P. 256.782.8054
www.jsu.edu