JOHNS HOPKINS UNIVERSITY
Homewood Student Affairs
Student Health
& Wellness Center

East 31st Street, N200
Baltimore, MD 21218
Tel: 410-516-8270 Fax: 410-516-4784

Student Reinstatement Questionnaire

Instructions: This portion of the form is to be **filled out by the student**. Please respond to the questions below and then give the form to your provider for completion. If more space is needed feel free to attach additional pages.

Full name:_____ Date of Birth:_____

What were the reasons that necessitated your taking a medical leave of absence from the University?

_____
_____
_____
_____

Should you return to the University what plans will you make to ensure your continued health?

_____
_____
_____
_____

Will you require any on-going services or treatments? Please explain:

_____
_____
_____
_____

Will you request disability accommodations, and if so what accommodations will you request? *(Not all requests can be fulfilled, if accommodations are desired, you will need to register with JHU Student Disability Services http://studentaffairs.jhu.edu/disabilities/admitted-students/)*

_____
_____
_____
_____

Treating Provider Reinstatement Questionnaire

Instructions: This portion of the form is to be **completed by the treating physician, nurse practitioner, or physician's assistant**. Please respond to the questions listed below, you may attach a statement or recommendation for reinstatement on your office letterhead as well. Send the completed statement to the address indicated. (If more space is needed to complete responses please feel free to place responses on your letterhead and attach to this form).

Are you a _____Medical doctor, _____Nurse practitioner, _____Physician's assistant?

Did you provide the evaluation and treatment for the above named patient? _____ Yes ____ No

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Were any specialists involved in the patient's care? If so, please list their names and contact information:

Specialty	Name of Provider	Contact information for Provider

Has the above named patient completed treatment? _____ Yes _____ No

When did the treatment commence? _____Conclude? _____

Describe diagnosis and treatment: (include any hospitalizations)

_____
_____
_____
_____
_____
_____
_____

How many visits have you had with the patient regarding this problem? _____

Is the patient currently requiring medication? _____ Yes _____ No

In your estimation, will the patient need to continue medication? _____ Yes _____ No

Please indicate medication and dosage(s):

Medication Name	Dosage	Frequency

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Will the patient require ongoing or additional treatments once they return to the University?
_____ Yes _____No. Please describe:
_____
_____
_____
_____

Would the patient benefit from disability accommodations? _____Yes ____No. Please describe:
(Requested accommodations may not be available, in order to receive accommodations additional documentation will be required, the patient will need to register with JHU Student Disability Services http://studentaffairs.jhu.edu/disabilities/admitted-students/)
_____
_____
_____
_____

Do you think this patient is capable of carrying a full academic load (12-19 credit hours) at an academically rigorous institution? ____Yes ____No, Please explain:
_____
_____
_____
_____

Other comments or additional recommendations:
_____
_____
_____
_____

_____ _____ _____
Signature of Treating Provider Printed name of Treating Provider Date

Note: *This information is confidential and will be used as an aid to make a recommendation to the Dean of Student Life Office for the purpose of reinstatement.*
The student should also complete the Consent to Release Information Form.

Return to:
Director, Student Health and Wellness Center Johns Hopkins University
1 East 31st Street N-200
Baltimore, Maryland 21218
Or fax to 410 516-4784 Attn: Director, SHWC