

## APPLICATION FOR RETURN FROM MEDICAL LEAVE

## PAGE 1: TO BE COMPLETED BY THE STUDENT

Last Name	First	Class Ye	ear	Skidmore ID#	
am applying to retu	urn to Skidmore for the foll	lowing term:	Fall 20	Spring 20	Summer 20
·	d supporting medical docur leave. This application will i ed deadline.				• •
Students must include a one-page academic plan that describes (1) their commitment to intellectual and personal growth, (2) a list of proposed courses for the upcoming term, (3) majors or minors they intend to explore, (4) their ability to balance academic responsibilities with co-curricular activities and social life, (5) any ongoing medical treatment, and (6) any appropriate campus support services they intend to utilize (e.g., Counseling Center, Health Services, Writing Center, Peer Academic Coaching, etc.).					
A licensed physician/clinician must include a letter of support on office letterhead that describes (1) the circumstances and concerns that prompted medical care, (2) a summary of past, current, and planned treatment, (3) the student's ability to be successful in a rigorous academic environment and live in a residential setting, and (4) any academic recommendations or accommodations.					
Return this form to: Office of Academic Advising, 815 North Broadway, Skidmore College, Saratoga Springs, NY 12866 Or send via email from student's Skidmore email account to: advising@skidmore.edu					
STUDENT AGREEMEN	NT:				
I have read and agree to the policies stated on the Office of Academic Advising's "Leaves of Absence" webpage regarding registration, housing, financial aid, and other stipulations.					
Student Signature					Date
FOR OFFICE USE ONLY					
Effective Date	_ CAS Approval (After Deadl	line)	Return on P	robation	Return on Waiver
Status List	Student File				



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## PAGE 2: TO BE COMPLETED BY THE STUDENT'S CLINICIAN/PHYSICIAN

Student's Last Name	Student's First Name					
PART 1: EVALUATION						
	closely with their clinician/physician to determine if they are ready to successfully tudent is expected to complete Page 1 of this application and provide a detailed luation and letter of support.					
Based on your professional opinio	on, please check one of the following boxes.					
	This student can function in a college environment with the ability to manage academic responsibilities, social life, selfcare, and living on campus in residential housing.					
This student can function well enough to return to Skidmore College but may benefit from a course load that is reduced or part-time (fewer than 12 credits).						
This student is not functio	oning well enough to return to Skidmore College at this time.					
Other, please explain:						
PART 2: LETTER OF SUPPORT						
been seeking treatment from. The care, (2) a summary of past, curre	pport on office letterhead from a licensed clinician/physician that the student has eletter should describe (1) the circumstances and concerns that prompted medical ent, and planned treatment, (3) the student's ability to be successful in a rigorous n a residential setting, and (4) any academic recommendations or accommodations.					
Please return the signed form and	accompanying letter to Skidmore College.					
By Mail: Office of Academic Advis By Email: advising@skidmore.edu By Fax: 518-580-5749	sing, 815 North Broadway, Skidmore College, Saratoga Springs, NY 12866					
PART 3: SIGNATURE OF CLINICIAN	I/PHYSICIAN					
Name of Clinician/Physician	Current State and License/Certification Number					
Signature of Clinician/Physician	Date					