**Leaves/Returns Committee** Haverford College Haverford, PA 19041

Phone: 610-896-1003

Email: [hc-leaves@haverford.edu](mailto:hc-leaves@haverford.edu)

Health Evaluation Form – Return from Medical Leave

This document is to be completed by a healthcare provider who is qualified to make a diagnosis or to provide treatment for a diagnosis. Please fill out the following information for your client and attach any appropriate supplemental documentation. If the student is receiving treatment from multiple relevant health care professionals, each provider must submit this documentation. Please send the completed form to the Leaves/Returns Committee via email. See contact information in letterhead.

Student Name:

Provider Name and Title:

Provider Phone: Email:

Provider Address:

City:

State: Zip:

1. Do you believe that this student is healthy enough to return to Haverford’s residential academic community and its rigorous course of study at this time? (Required)

Yes No 

1. What specific indicators support your assessment that the student is able to resume their studies at Haverford College at this time? (Required)



1. Briefly describe the nature, duration, and frequency of the treatment(s) you provided. (Required)



1. Do you have any concerns about the student’s readiness to return to Haverford at this time? (Required)

Yes No 

Please provide any necessary details below:

5. Will the student need ongoing treatment, support, or accommodations upon return to Haverford? (Required)

Yes No 

If yes, please describe your recommendations:



Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_