OFFICE OF THE VICE PRESIDENT
FOR STUDENT AFFAIRS
JACKSONVILLE STATE UNIVERSITY

Licensed Provider Recommendation for Return to Campus

Provider Name:___________________________________Phone:_________________

Address:____

Provider Credentials: Circle 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's 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 Stamp Date

700 Pelham Road North
Jacksonville, AL 36265-1602
P.256.782.5020
P.800.231.5291
F.256.782.8551
www.jsu.edu

An Equal Opportunity | Affirmative Action Employer