



Request for Medical Leave of Absence

Your patient has requested to take a medical leave of absence from Syracuse University. Please provide confirmation of this diagnosis and severity by completing this form and returning with attached relevant progress notes, diagnostic tests and/or treatment. This form is to be completed by a medical provider.

Please complete and return this form and any additional documentation by mail to Syracuse University, Barnes Center at The Arch, ATTN: Hannah Mazzoni, 150 Sims Drive, Suite 201, Syracuse, NY 13244, or by fax to 315.443.2841. For questions, please call Barnes Center at The Arch Health Care at 315.443.8000.

Student's full name: _____ Date of birth: _____ Medical diagnosis: _____

Date the medical condition resulted in the student to take a medical leave of absence: _____

Treatment length: _____ Estimated recovery time: _____ Last scheduled visit: _____

Is the medical condition permanent or cyclical?

Describe the likely impact on academic performance if this request is not granted:

In your medical opinion, does the student require a medical leave of absence? Please explain.

By signing, I verify that a designated staff member or I have completed this form, that I am treating this patient and that I am not a relative of this patient.

Full name of provider: _____ Provider license number: _____

Provider address: _____

Provider signature: _____ Date: _____

Barnes Center at The Arch Health Care

150 Sims Drive, St. 201, Syracuse, NY 13244

T 315.443.8000 syracuse.edu/BeWell