

Saint Mary's College of California
REQUEST FOR MEDICAL/PSYCHOLOGICAL DOCUMENTATION
Office of the Assistant Vice Provost for Student Success

MEDICAL/MENTAL HEALTH PROVIDER -- PLEASE RETURN COMPLETED FORM DIRECTLY TO:
Academic Probation Review Board via email to aprb@stmarys-ca.edu

PART I. TO BE COMPLETED BY THE STUDENT :

(If more than one physician is treating this condition, please provide a separate copy of this sheet to each).

Parts II and III to be completed by the student's treating, licensed, non-familial, health care professional

PART II.

<u>CERTIFYING PROFESSIONAL AND TITLE</u> : (please print)	<u>LICENSE #</u> :
D	

Continued Student/Patient: _____

PART III. PLEASE INDICATE THE IMPACT OF THE CONDITION AND /ITS TREATMENT ON THE FOLLOWING :

	N / A	MODERATE IMPACT	SEVERE IMPACT	DESCRIPTION OF IMPACT IF MODERATE OR SEVERE
Treatment / Medication Side Effects				
Pain				
Walking / Standing / Sitting				<i>Include distance / duration / assistive devices</i>
Performing Manual Tasks i.e. writing, keyboarding				<i>Include duration</i>
Breathing				
Hearing / Vision				
Sleeping				
Delusions / Hallucinations				
Obsessions / Compulsions				
Mood / Emotional Regulation				