Community Provider Report Form

This form must be submitted via mail no later than 30 days before the start of classes.

This form must be completed by the student's community clinician/service provider and emailed directly, mailed, or faxed from the provider to:

Email	Mailing Address	Fax
wellness@sandiego.edu	University of San Diego, Wellness Area 5998 Alcalá Park, SH 300 San Diego, CA 92110	619-260-4699

PLEASE PRINT

Clinician's Name: ____ Current Phone Number: (_____) _______ - ________

Licensed as: _______________________ License #: _______________________ State of License: _______________________

Student's Name: ____

Last, First and Middle

Date of 1st session: _____ / _____ / _______

Date of most recent session: _____ / _____ / _______

Total # of treatment sessions: _______________________

Initial Diagnosis: ____

Current Diagnosis: ____

Please provide your professional judgment in response to the following questions regarding the student named above.

1. Has there been a substantial amelioration of the student's original medical/psychological condition?
   ▢ Yes ▢ No
   If **yes**, please check all of the following that you have observed a marked reduction of in this student:

   ▢ # of Symptoms
   ▢ Severity of Symptoms
   ▢ Persistence of Symptoms
   ▢ Functional impairment
   ▢ Subjective level of client distress

2. In your opinion, is the student able to function safely, stably, and successfully as a full time university student at this time?
   ▢ Yes ▢ No

   Please Explain:

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3. If applicable, in your opinion, is the student able to live in the Residence Halls safely, stably, and successfully at this time?
▢ Yes ▢ No

Please Explain:

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4. Do you plan to continue to provide treatment if the student is reinstated at USD?
▢ Yes ▢ No

Please Explain:

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If "No", what recommendations for treatment have you made and how has the student secured needed services to support your recommendations?

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Clinician's Signature: ____ Date: _____ / _____ / _______