WILLIAMS COLLEGE WILLIAMSTOWN, MASSACHUSETTS 01267

OFFICE OF THE DEAN
P.O. Box 518
Tel. (413) 597-4171

STUDENT READINESS TO RETURN FROM HEALTH-RELATED LEAVE

Dear Health Care Provider:

A Williams College student, identified on the following form, is seeking permission to return to the College following a health-related leave. The information you provide on the following form will help the College determine whether the student is ready to return to a rigorous academic program and live in a residential college environment. The information you provide also will help the College determine whether any campus resources will be needed for the student to make a successful reintegration into our community and maintain his or her well-being.

In addition to answering the specific questions on this form, please provide any additional commentary you believe is relevant to the student's readiness to return to the College, either on the form itself or on additional pages as necessary.

PLEASE NOTE: During the summer months at Williams College (June-August) there are no academic classes, so the health center and counseling center do not function in their typical capacity. Instead, Williams College provides for students to have access to telehealth mental health services through Talkspace, including up to four 30-minute video sessions per month and video psychiatry sessions. There is also an on-call answering service via phone for psychological emergencies. ***There are no on-campus clinical services provided in person until the fall semester begins in August.*** *As you assess both potential safety risks of the student returning to campus during the summer, and any recommended mental health services needed in follow-up, please be aware that these telehealth services are the only ones provided by the College in summer.*

Thank you very much.

Student Name:_____Date: _____

Please describe the injuries, illnesses or conditions for which you have been treating or evaluating the student.

Please indicate the time period(s) in which have you provided those services to the student, including the last time you saw the student.

What is the student's current status and prognosis?

Will the student require any ongoing or recurring treatment or other supports? If so, please describe what the treatment or supports should involve and what arrangements for such treatment or supports have been made or remain to be made.

Is the student ready to re-engage in a rigorous collegiate academic program (i.e., attend classes, meet deadlines, complete work in a timely fashion, seek assistance as needed)? If there are any qualifications to your answer, please explain.

Is the student ready to resume living independently in a residential college environment? If there are any qualifications to your answer, please explain.

Does the student require any academic or other accommodations? If so, please describe the accommodations you believe are required, and why.

Does any aspect of the student's condition present a material risk of self-harm or harm to others? If the answer is "yes," "potentially," or "it depends," please explain.

HEALTH CARE PROVIDER INFORMATION

Name: _____

Licensed as: _____ License #: _____ State: _____

Address: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

PLEASE SAVE A COPY OF THIS FORM AND UPLOAD TO:

Secure Drop Box Link

OR

Fax: (413) 597-3507

Email: chaley@williams.edu with questions

BY:

1 July - return for the following fall semester

1 December - return for the following spring semester