Leave of Absence Return
Provider Information Form

Please fill out the form below and attach appropriate supplemental documentation for your client _____.
Thank you in advance for your support and cooperation.

Practitioner Name/Title _____ Date _____

Address _____

Telephone _____ FAX _____

Specialty/qualification to make diagnosis _____

1. Diagnosis, instruments and procedures for diagnosis, date of diagnosis and dates of attendance/clinical visits.

   _____

   _____

   _____

2. Describe the treatment provided.

   _____

   _____

3. Severity of condition. (Mild, Moderate, Severe) _____

4. List current medication(s), dosage frequency and adverse effects.

   _____

   _____

5. Please indicate prognosis and recommendations for return. Each recommendation must be supported by the diagnosis.

   _____

   _____

   _____

6. Additional comments: