This form provides a plan for your health leave (medical separation). This health plan is between your doctor and you. It includes information (called a “referral”) about a provider or clinic that you can go to for treatment and the steps you need to take to return to center within 180 days. While on health leave, you are responsible for your own medical bills. This is your copy; the original form is kept in your Job Corps student health record.

**Please let Job Corps know if your phone number or addresses changes while you are on health leave. Center health staff will contact you each month while you are on health leave to check on your progress.**

|  |  |  |
| --- | --- | --- |
| **Student Information** *may be completed by nurse* | | |
| **Student Name:** | Other type of leave considered appropriate? Yes  No | |
| **ID#:** | **\* If yes, which type and dates of leave:** | |
| **Job Corps Center:** | Admin  PTO  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **MSWR start date in CIS:** | Dates of leave: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Anticipated date of return:** | Disability accommodations considered?**1**  Yes  No | |
| **Health and Wellness Director** *(name, title):* | | |
| **Clinician/Qualified Health Professional Completing Form** *(name, title):* | | |
| **Reason for Health Leave** *may be completed by nurse* | | |
| **Check one or more boxes for the type of health leave.** *No clinical information should be written in this section. The center clinician or other qualified health professional (QHP) must document their clinical assessment in the Student Health Record (SHR), including a diagnostic code.*  Medical  Mental Health  Substance Use  Pregnancy  Oral Health  OWCP for injury *(applicable forms included)*  Direct Threat to Others. ***PRH Form 2-04 must be completed by clinician and placed in the student health record.*** | | |
| **Individualized Treatment Instructions** *must be completed by clinician* | | |
| Symptoms, behaviors, or conditions requiring treatment:  Treatment instructions to stabilize or improve the specific symptoms or problems listed above:  Your treatment records need to show that your condition(s) or symptoms have stabilized or improved.   |  |  | | --- | --- | | You need to be evaluated by a licensed or certified health care provider or specialist (type:      ) and follow their treatment recommendations to get better. | Yes  No  Does not apply | | You need to be evaluated by a licensed mental health provider and follow treatment recommendations to stabilize the mental health symptoms listed above. | Yes  No  Does not apply | | You need to be evaluated by a licensed medical provider (including a psychiatrist, if needed) to figure out if medications could help to improve your condition. | Yes  No  Does not apply | | Your current medications need to be reviewed by a medical provider to see if any changes could help to improve your condition. | Yes  No  Does not apply | | | |
| **Referral(s) for Treatment** *may be completed by nurse.*  *Skip this section if student prefers to see their own provider.* | | |
| You must be offered information (“a referral”) for at least one provider or clinic to get the treatment that you need or you can choose to see your personal provider or another provider of your choice (documented in the next section).   |  |  | | --- | --- | | Referral Provider/Clinic Name: |  | | Referral Phone Number: |  | | Referral Address: |  | | Referral Email or Website *(optional)*: |  | | Appointment Date and Time *(optional)*: |  | | | |
| **No Referral for Treatment Needed** *may be completed by nurse* | | |
| If you want to see your personal health care provider or another provider that you choose for treatment, please provide the following information:  Personal Provider or Clinic Name:       Phone Number: | | |
| **Transportation Details** *may be completed by nurse* | | |
| |  |  | | --- | --- | | A center staff member will transport you. | A family member/friend that you know will pick you up. | | A bus ticket will be provided to you. | A plane ticket will be provided to you. | | A train ticket will be provided to you. | Other: | | | |
| **Student requires an escort** (*based on the clinician’s assessment*)  Yes  No  \***If yes**, name of escort and title/relationship: | | |
| **Individualized Steps to Return to Center** *must be completed by clinician* | | |
| 1. Provide copies of your treatment records, including records from any specialists you saw, to the Health and Wellness Center. Your health care provider or clinic can fax your treatment records directly to      or email them to: 2. Let us know what you may need to maintain stability or recovery of your condition after you return, such as medications or continued treatment. (This information may be included in your treatment records.) 3. Let us know about any disability accommodations that you may need to participate in the program. 4. Additional Steps: | | |
| **What the Center Does Next** | | |
| * After you or your health care provider sends us your treatment records**, a center health staff member will review your records and contact you to discuss the treatment you received and your ability to participate in Job Corps**. The center staff may ask for your written permission to talk to your health care provider. * Job Corps health staff will determine whether you are ready to return to the center from your health leave. * You may be contacted by a center Disability Coordinator to determine if you need disability accommodations. | | |
| **Job Corps Staff Signatures** | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Center Clinician or QHP Signature | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |
| Health and Wellness Director Signature | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |
| **Student Consent and Signature2** | | |
| **Signing this form means that you understand the information on this form and that you were able to ask questions and get answers to your questions.** *Please check one box:*  **I agree (consent) to health leave (medical separation with reinstatement rights or MSWR).**  **I do not agree (consent) to health leave (medical separation with reinstatement rights or MSWR).**    Student Signature Date Off-center contact number(s)  ***Student was not available to sign the form but provided verbal consent as documented in SHR.*** | | |
| *Optional:*  MSWR End Date (180 days): | Date of student return from MSWR: | |