Community Provider Report Form

Andrews University

Bell Hall Suite 123
Berrien Springs, MI 49104
(269) 471-3470

Please Print:

Note: This form is to be completed by the student's community mental health provider and mailed by the provider directly to CTC at the address indicated above. "Provider" means doctoral level Licensed Healthcare Provider (e.g., MD, DO, Psychologist, Licensed Clinical Social Worker, etc.). This original, signed licensed provider form must be received no later than 2 weeks prior to planned semester of return. Faxed or photocopied documents will not be accepted.

Clinician Name: _____ Degree: _____ Student Name:_____

Licensed as: _____ Date of First Session: _____

License #: _____ Date of Most Recent Session: _____

State of Licensure: _____ Total # of Treatment Sessions: _____

GAF Score at Start of Treatment: _____ GAF Score at End of Treatment: _____

Initial DSM Axis I Diagnosis: _____ Current DSM Axis I Diagnosis: _____

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