Re-enrollment Checklist for Columbia Health Services Medical Evaluation

Student Name: ____________________________________________

Student UNI: ____________________________________________

Date: ____________________________________________________

To be completed by CMS health practitioner:

Please check as appropriate

1. Student is **cleared** to re-enroll

2. Student is **not cleared** to re-enroll

Recommendations:

1. ODS registration

2. Follow-up appointment with CHS or appropriate health care provider

3. Follow-up appointment with CPS or appropriate health care provider

4. No recommendations

5. Please check if you recommend part-time enrollment only

CHS practitioner signature: ________________________________

CHS practitioner printed name: _____________________________

Title: __________________________________________________

Please place in a signed/stamped and sealed envelope to be hand-delivered by the student to the SPS Office of Student Affairs, Lewisohn Hall Room 203A. Thank you.