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 SCE Office of Student Life and Alumni Relations, Lewisohn Hall Room 203A. Thank you.