COLUMBIA UNIVERSITY
School of Continuing Education

# 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.