Revised Date

November 2014

I. Statement of Policy:
Students may request a medical or personal leave of absence from the School of Nursing.

II. Scope:
Students enrolled in the School of Nursing.

III. Attachments:
A. Leave of Absence Request Form
B. Medical Leave Form
C. Student Return to School Certification Form

III. Procedure:
A. Students who wish to request a leave of absence will complete the Leave of Absence Request Form and submit it to their faculty advisor. If a medical leave is requested, the student's health practitioner must complete the Medical Leave Form.

B. The advisor will arrange for a meeting with the Director to discuss the leave of absence.

C. When considering the leave of absence, the following factors will be taken into account:
   a. Current and past academic performance.
   b. Length of time requested.
   c. Where the absence would fall in the semester.
   d. Whether class and clinical time could be made up

D. Additional documentation may be requested from the student (i.e. if a family member is ill, documentation from their health care provider may be requested).

E. Students may be advised to withdraw from the program rather than take a leave of absence if it is determined that the leave cannot be accommodated.

F. The leave should not necessitate that a student will be unable to complete more than one semester. If that occurs, the student may be considered for involuntary withdrawal.

G. Students who are granted a leave of absence are subject to all financial obligations to the School of Nursing. If the student cannot return after the leave of absence, the tuition reimbursement rates are as follows:
   a. If the student withdraws during the first week of classes, they get a 100% tuition refund.
   b. If the student withdraws during the second week of classes, they will get an 80% tuition refund.
   c. If the student withdraws after the second week, no tuition will be refunded.

H. Students enrolled in affiliate college courses must follow the policies of that college.

I. Prior to returning to school after a medical leave, the student must have their health care practitioner complete the Student Return to School Certification Form.

GEISINGER LEWISTOWN HOSPITAL SCHOOL OF NURSING

REQUEST FOR LEAVE OF ABSENCE

Student Name: _____

I hereby apply for a Leave of Absence beginning: _____.

The anticipated length of my leave of absence is: _____.

Reason for Leave: (Check the appropriate box.)

- ❒ My medical condition.
- ❒ Family member's serious medical condition (family member: _____
- ❒ Birth of a Child
- ❒ Adoption/ Placement of Foster Child
- ❒ Personal - please explain: _____.

I understand that **it is my responsibility** to ensure that **ALL** required **documentation is provided by the healthcare provider before** this LOA request is considered for eligibility requirements and/or approval. It is also my responsibility to provide periodic updates from my physician or other health care provider.

I understand that, if I do not report back to school before the expiration of the above leave, unless a properly authorized extension has been granted prior to the expiration of the leave, I will be involuntarily withdrawn from the program.

NOTE: Before returning from a Medical Leave of Absence, a "Return to School" Form signed by the healthcare provider **MUST** be submitted to the School of Nursing faculty advisor for final approval.

_____ _____
Student Signature Date

Faculty Approval:

Approved Not Approved

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

GEISINGER LEWISTOWN HOSPITAL SCHOOL OF NURSING
PHYSICIAN OR PRACTITIONER CERTIFICATION

Student Name: _____

Patient's Name (if other than student): _____

Diagnosis: _____

Student's first day off: _____ **Approximate date of return to school**: _____

Prognosis: _____

_____

Regimen of treatment to be prescribed (Include general nature, frequency, duration of treatments):

_____

_____

COMPLETE IF THIS CERTIFICATION RELATES TO THE <u>CARE OF THE STUDENT</u>:

Yes	No	
❒	❒	Is inpatient hospitalization of student required?
❒	❒	Is student able to meet clinical expectations with or without restrictions? Please Specify restrictions_____

COMPLETE IF THIS CERTIFICATION RELATES TO THE <u>SERIOUSLY ILL FAMILY MEMBER</u>:

Yes	No	
❒	❒	Is the student's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) Please estimate the period of time care is needed, or the student's presence would be beneficial: _____

_____ _____

Signature of Physician or Practitioner Date

_____

Print name of Physician or Practitioner

GEISINGER LEWISTOWN HEALTHCARE FOUNDATION

STUDENT RETURN TO SCHOOL CERTIFICATION

(To be completed by treating physician.)

Student name: _____
Date of injury or illness: _____
Can student return to school with no restrictions?

Yes ____ - date can return with no restrictions: _____

No ____ - date can return with restrictions: _____ (Please complete the following):

In an 8-hour day, student can work as follows (circle full capacity for each).

Sit	1	2	3	4	5	6	7	8	Hrs/Day	No restriction
Stand	1	2	3	4	5	6	7	8	Hrs/Day	No restriction
Walk	1	2	3	4	5	6	7	8	Hrs/Day	No restriction

Student can lift/carry (please check as appropriate):

	Never		Occasionally		Frequently		No Restriction
	Lift	Carry	Lift	Carry	Lift	Carry	
0 - 10 lbs.	____	____	____	____	____	____	____
11 - 20 lbs.	____	____	____	____	____	____	____
21 - 50 lbs.	____	____	____	____	____	____	____
51 - 100 lbs.	____	____	____	____	____	____	____
100 + lbs.	____	____	____	____	____	____	____

Student can use hand repetitively (please check as appropriate):

	Simple Grasping		Fine Manipulation		Pushing/Pulling	
	Yes	No	Yes	No	Yes	No
Right	____	____	____	____	____	____
Left	____	____	____	____	____	____

Student can use feet for repetitive movement such as foot controls (please check as appropriate):

	Yes	No	Hours/Day
Right	____	____	____
Left	____	____	____

Student can drive (please circle the appropriate statement):

Not at all Occasionally Frequently No Restriction

Student is able to (please check as appropriate):

	Not at all	Occasionally	Frequently	No restriction
Bend	____	____	____	____
Climb	____	____	____	____
Crawl	____	____	____	____
Kneel	____	____	____	____
Squat	____	____	____	____
Reach Outward	____	____	____	____
Reach Above	____	____	____	____
Twist	____	____	____	____
Push	____	____	____	____
Pull	____	____	____	____

Categories of work provided at Lewistown Hospital (please choose category recommended for student):

____ Sedentary work	Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles, including papers, books, folders, small office tools and supplies. The sedentary job is mostly sitting, occasional walking and standing may be required.
____ Light work	Lifting 20 lbs. maximum with frequent lifting and/or carrying objects weighing up to 10 lbs. This job involves frequent sitting, walking and standing on occasion.
____ Medium work	Lifting 50 lbs. maximum. Frequent lifting and/or carrying of objects weighing up to 25 lbs.
____ Heavy work	Lifting 100 lbs. maximum. Frequent lifting and/or carrying of objects weighing up to 50 lbs.
____ Very heavy work	Lifting objects in excess of 100 lbs. with frequent lifting and/or carrying of objects weighing 50 lbs. or more.

COMMENTS/SPECIAL RESTRICTIONS:

_____

_____ _____

Healthcare Provider Signature **Date**