SOUTHEASTERN LOUISIANA UNIVERSITY
Office of Student Conduct
SELU 10390, Hammond, LA 70402
Ofc: 985-549-2213 Fax: 985-549-5103
www.selu.edu/studentconduct

Treatment Verification

To the student: You are responsible for attending treatment with a licensed mental health professional. When you have completed treatment sessions or while undergoing treatment, you must have the licensed mental health professional or his/her designee complete and sign the bottom portion of this form. **It is your responsibility to return this completed form to the Office of Student Conduct, War Memorial Student Union, Room 205 bi-monthly until treatment is completed and again when treatment is concluded.** This form is proof that you have either completed or are working toward completion of your sanctions as required by the Office of Student Conduct, and it will become a part of your disciplinary record.

STEP 1: To be completed by the student: Consent for Release of Information for verification purposes.

I, ____, W# ________________________
Student's printed name

hereby authorize the exchange of information between the individual(s) listed below and Southeastern University Office of Student Conduct and the University Counseling Center through written, verbal or electronic* means for the purpose of determining completion of or continued treatment toward completion of my sanctions. I consent to consultation between the above-mentioned University departments and my mental health provider.

__________________________________ ____________________
Student's Signature* **Date**

By signing above, you give the licensed mental health professional consent to release comments and/or suggestions regarding treatment.

Mental Health Prof.	
Agency	
Address	
Phone #	

May your information be faxed and/or emailed? ________ Yes ________ No
(*Confidentiality cannot be assured through use of electronic communication such as fax and email.)

STEP 2: To be completed by the Mental Health Professional:

____, __________________________________
Print Student's Name **W#**

a Southeastern Louisiana University student has received treatment.

Recommendations:

_______ **Continue treatment on a** ____________________________ **(weekly, bi-weekly, monthly, etc.) basis.**

_______ **Treatment is COMPLETE and student is released from care.**

Additional Comments:____
____
____
____

____ **Date:**___________________
Print your Name, Degree, and License type (M.D., LPC, LCSW, etc.) as attending physician/psychiatrist/ other licensed mental health profession. **Phone:**__________________