You are required to complete an assessment at your own expense administered by a licensed mental health provider. In order to complete this sanction successfully, you must follow the steps below.

1. Choose a state accredited treatment facility/program. The Office of Student Conduct can provide you with a list of local agencies [www.southeastern.edu/studentconduct/communityservices](http://www.southeastern.edu/studentconduct/communityservices). The University Counseling Center (UCC) is available to students at no charge. Should you decide to have this assessment done by the UCC; an appointment can be scheduled by calling, 985-549-3894.

2. Complete the Consent for Release of Information below for verification.

3. The assessment agency must complete the bottom portion with your results and recommendations before considered absolute.

4. You must return the completed form to the Office of Student Conduct upon completion of the assessment. Please note recommendations of the Mental Health Professional are generally incorporated into the sanctions.

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

I, ______________________________________________________, W# (SID) __________________
Southeastern Louisiana University Student, 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 a counseling assessment, receiving recommendations, and completion of treatment plan. I consent to consultation between the above-mentioned University departments and my mental health provider.

<table>
<thead>
<tr>
<th>Mental Health Provider:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Agency:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone #:</td>
<td></td>
</tr>
</tbody>
</table>

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

_________________________________________ Date
Student's Signature

II. To be completed by the attending physician/licensed mental health professional conducting assessment.

_____ 1. CONTINUES TREATMENT – Projected Release Date: _____/_____/______ (mm/dd/yyyy)

_____ 2. NO TREATMENT RECOMMENDED.

Additional Comments: ____________________________________________________________

Name, degree, and license type (M.D., LPC, LCSW, etc.) ____________________ DEA # ___________ Date

Phone # for Verification ____________________ E-MAIL: __________________

III. To be completed by the attending physician/licensed mental health professional conducting treatment.

_____ Treatment requirements have been met/No additional treatment warranted at this time. Must be released before the conduct case is considered CLOSED.

Additional Comments: ____________________________________________________________

Name, degree, and license type (M.D., LPC, LCSW, etc.) ____________________ DEA # ___________ Date

Phone # for Verification ____________________ E-MAIL: __________________

It is the student’s responsibility to return this completed form to the Office of Student Conduct, SU 1305. This form is proof that you have attended the treatment screening, received recommendations, and completed the treatment plan as required and will become part of your disciplinary record. Failure to follow the recommended treatment plan will result in further disciplinary action and/or a Registration Hold until obligation is satisfied.