**Dean of Students Office**
**Lindsey Vega, Assistant Dean of Students**
**University of North Carolina at Greensboro**
**Elliott University Center, Suite 210**
**Greensboro, NC 27402**
**Phone: 336.334.5514 Fax: 336.334.5190**

---

# Verification of Counseling/Treatment

**Instructions to Student:** Please fill out your name and student ID # and provide a copy of this form to your health care provider to verify your attendance at therapy/treatment. **The form will not be accepted without a proper signature from the provider**. The form then must be ***mailed, faxed, or hand delivered to the Dean of Students Office within 48 hours of the appointment.*** If FAXED, please call first and then fax to (336) 334-5190.

Student Name:__________________________________

Student ID number:__________________________________

---

**Instructions to Community Provider:** The person named above is a student of the University of North Carolina at Greensboro. Due to a recent concern, this student has agreed to utilize health care services in the community until the student and his/her health care provider mutually agree that regular therapy/treatment is no longer necessary. This form is used to verify that the student is attending therapy/treatment as agreed upon with the university.

Provider/Clinician Name: _______________________________ Professionally Licensed as: ____________________________

License #:_______________________ State of Licensure: ______________________

Contact Information for Provider: _____________________________ Place of Practice: _______________________________

**Most Recent Appointment Date: ____________________ Next Appointment Date: __________________________________**

Termination of Therapy or Treatment Date: _______________________________________

***(Please fill out date only if it has been mutually agreed upon between provider and client)***

| Risk Level | Risk/Protective Factor | Suicidality |
|---|---|---|
| ***High*** | Psychiatric diagnosis with severe symptoms, or acute precipitating event, protective factors not relevant | Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal |
| ***Moderate*** | Multiple risk factors, few protective factors | Suicidal ideation with plan, but no intent or behavior |
| ***Low*** | Modifiable risk factors, strong protective factors | Thoughts of death, no plan, intent or behavior |
| ***No*** | No risk factors, strong protective factors | No thoughts of death, no plan, intent or behavior |

**Risk level at time of meeting: _________________________**

| **Has there been a reduction in safety related behaviors the student may have been engaging in?** | | | | |
|---|---|---|---|---|
| Yes | No | Maybe | NA | Threats/aggressive behaviors toward self & others |
| Yes | No | Maybe | NA | Substance abuse behaviors |

Comments:

Community Provider Signature*:* ________________________________________________ Date: ________________________

***Form will not be accepted without proper signature***

**NOTE:** The student will be required to have this form completed after each session by the student's community provider. The The form must be submitted to the Dean of Students Office within 48 hours of the appointment.

Rev. 3/10/20