Counseling Compliance Form

(TO BE COMPLETED BY STUDENT)

Dean of Students Office
P.O. Box 8795
Williamsburg, VA 23187-8795
757-221-2510
757-221-2302 (TTD)
757-221-2538 (FAX)

Student Name: _____

Student ID Number: _____

_____ _____

Address Phone Number

I, _____, agree to remain actively engaged in counseling at the frequency agreed upon with my counselor, whose name and contact information I provide below. I authorize the Assistant Dean of Students for Disability Services to contact this counselor concerning my compliance with this agreement. I agree to continue active engagement in the counseling process throughout the semester for which I receive accommodation or until no longer necessary. In the even that I discontinue counseling, whether or not I do so at the discretion of my counselor, I agree to notify the Assistant Dean of Students for Disability Services. I understand that in order to receive accommodation, I must comply with the aforementioned statements. I further understand that my need for accommodation will be assessed on a semester by semester basis.

_____ _____

Student Signature Date

Counselor Information:

Name: _____

Practice: _____

Phone: _____

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To be Filled Out by Student

Student Name:_____ Student ID #: _____

I understand the purpose and intent of this follow up form and I give my healthcare professional permission to share the information that has been requested by The College of William and Mary

_____ _____

Student Signature Date

To be Filled Out by Counselor

The student listed above has been asked to provide verification of his/her active engagement in counseling for the treatment of an anxiety disorder. Please indicate pertinent information for the categories below. After completing this form, you may return it by fax or mail. Please attach a cover sheet marked *Confidential-Attn: Disability Services* if faxed.

Date of Initial Meeting with Student: _____

Agreed-Upon Frequency of Counseling Sessions: _____

Treatment Dates for this Semester: _____

Student's Engagement in Therapy (circle one): Excellent Very Good Good Poor

I understand that I may be asked to verify this client/patient's regular attendance of counseling sessions for the current school semester.

_____ _____

Signature of Counselor Date

_____ _____

Printed Named of Counselor Phone Number

_____

Name of Practice