Medical Documentation Form

To be completed by student (Please Print)

Name: _____ ID#: **S**_____

Address: _____ Phone Number: _____

I authorize the release of any medical information necessary to process this Enrollment Services request/appeal:

_____ _____

Student Signature Date

MEDICAL INFORMATION (To be completed by physician):

Physician's Name: _____ Medical Specialty: _____

License Number: _____ Phone Number: _____

Address: _____

_____

Date of illness, injury, or condition: _____

Would this prevent student from participating in his/her course(s) study? (___) YES (___) NO

If yes, please indicate the time period that the student would be unable to participate:

From _____ to _____
Date *Date*

Circumstances/Restrictions *(Please explain in laymen's terms):*

_____

_____

_____

I attest the above information to be true and accurate.

_____ _____

Physician's Signature Date

_____

Physician's Stamp

Return to:
Red Rocks Community College
Enrollment Services
13300 W. 6th Ave, Campus Box 5
Lakewood, CO 80228-1255
Fax: 303-914-6457
Email: enrollmentservices@rrcc.edu

This form MUST be returned directly to Enrollment Services from the Physician's office via email, mail or fax and must be received NO LATER than the census/drop date for the following term!

Revised 09/09/2015