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 the 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*

Please indicate which class modality/modalities this would prevent the student from participating in:

Online (Asynchronous) (__) Remote (Synchronous) (__) In-person (Synchronous) (__)

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: 303-914-6817
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 04/21/2023