PIKES PEAK COMMUNITY COLLEGE
Medical Documentation Form for Appeals

Name: _____ Student ID #: _____
Address: _____ Phone number: _____
_____ DOB: _____

I authorize the release of my medical information and documentation necessary to process this appeal.

_____
Student Signature Date

Student do not write below this line or the appeal will be returned or denied.

MEDICAL OFFICE USE ONLY
Form must be completed in full. If blank spaces exist below, the appeal will be returned or denied.

Medical Professional Name	
Medical Specialty	
Medical License #	
Medical Office Address	
Medical Office Phone	

Is this appeal due to the student's own medical condition? ( ) Yes ( ) No
If YES, briefly describe below how the student's condition prevented them from attending school and/or completing coursework.

Is this appeal due to the student serving as primary caregiver for an immediate family member? ( ) Yes ( ) No
If YES, briefly describe below how the family member's condition and the student's role as primary caregiver prevented the student from attending school and/or completing coursework.

Would these circumstances have negatively affected or prevented the student's ability to participate in on-campus course(s) at the time of illness/injury? ( ) Yes ( ) No

Would these circumstances have negatively affected or prevented the student's ability to participate in online course(s) at the time of illness/injury? ( ) Yes ( ) No

If YES, please indicate the time period that the student would have been unable to participate.
From____/_____/_____ to _____/_____/_____

Has the student's/family member's condition improved enough to allow the student to return to school?
( ) Yes ( ) No If YES, as of what date? _____/_____/_____

_____
Licensed Professional Signature Date