



STUDENT APPEAL FOR TUITION CREDIT MEDICAL DOCUMENTATION FORM

To be completed by student:

Name: _____ SID: _____
Address: _____ Phone Number: _____

I authorize the release of any medical information necessary to process this appeal.

Student signature Date

To be completed by physician:

Physician's Name: _____ Address: _____
Medical specialty: _____
Date of illness, injury _____
or condition: _____
Phone Number: _____

Please explain how this illness, injury or condition prevented this student from attending class(es) and/or completing coursework:

I attest the above information to be true and accurate.

Physician's signature Date

Physician's stamp

Return to:
Arapahoe Community College
Campus Box 35
5900 S. Santa Fe Drive
P.O. Box 9002
Littleton, CO 80160-9002