Medical/Mental Health Form

Student Section:

Name: _____Student S#_____

FRCC Campus Location: _____ Affected semester(s) _____Fall _____Spring ____Summer Year(s) _____

"I authorize my health care provider to complete and release information to Front Range Community College"

Student Signature: _____Date:_____

Health Care Professional Section:

(To be completed by a medical/mental health practitioner)

Health Care Professional Name (please print) _____Title:_____

Address: _____ Phone Number: _____

License # and state issuing license_____

What dates did the student's condition prevented them from attending college/completing class work?

From_____To_____

Did the student's condition negatively affect their academic performance and/or ability to pursue normal activities?

_____Yes
_____No

Has the student's condition improved enough to allow them to return to FRCC and successfully complete college-level coursework?

_____Yes If yes, please indicate as of what date: _____
_____No I do not recommend the student return to college at this time and should withdraw from all courses

Additional Comments:

Professional Practitioner Signature: _____Date:_____

***Please return form to: Front Range Community College*:**

Larimer Campus	Westminster Campus	Boulder County Campus	Online Learning
Welcome Center Desk	Welcome Center Desk	Welcome Center Desk	Boulder County Campus
4616 South Shields St. MA150	3645 W. 112th Ave. C0552	2190 Miller Dr. A1304	2121 Miller Drive C1614
Fort Collins, CO 80526	Westminster, CO 80031	Longmont, CO 80501	Longmont, CO 80501