MCC Medical/Mental Health Form

Student Section:

Name: ____Student SID#________________________________

MCC Campus Location: __________ Affected semester(s) ____Fall ____Spring ___Summer Year(s) _______

By signing below, I authorize my health care provider to complete and release information to Morgan 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____

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

   From________________________________To_____________________________________

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

   __________ Yes

   __________ No

3. Has the student's condition improved enough to allow them to return to MCC 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:

Morgan Community College
Financial Aid Office
920 Barlow Road
Fort Morgan, CO 80701