MIKE DEWINE
OHIO ATTORNEY GENERAL

Ohio Peace Officer Training Commission
Office 800-346-7682
Fax 740-845-2675

P.O. Box 309
London, OH 43140
www.OhioAttorneyGeneral.gov

OPOTC MEDICAL EXTENSION REQUEST FORM

Student Name: _____ _____ _____
(Last) (First) (Middle)

Student Address: _____

School Name: _____

School Address: _____

_____

School Number: _____ School Start Date: _____

OPOTC Compliance Officer Name: _____

The above-named student has provided to me an "OPOTC Injury/Medical Condition Examination Form," signed by a medical doctor (MD), osteopath (DO), physician's assistant (PA), or certified nurse practitioner (CNP) licensed by the Ohio State Medical Board or the Ohio State Board of Nursing, or neighboring state's equivalent, and has asked that I request an extension of time for them to complete _____. A copy of this document is attached to this form. I have reviewed this document, and I support the student's request. I hereby request a medical extension to allow this student to recuperate and participate in this topic(s). I have informed the student that prior to participation, the student must produce an "OPOTC Medical Release Form," signed by their MD, DO, PA, or CNP, releasing them to full activity. If this is an extension of a physical fitness assessment, I have informed the student that the assessment will be held at OPOTA, London campus, and will include sit-ups, push-ups, and a 1.5 mile run, and that the student must meet the established requirements in each event. Finally, I have informed the student that, should the student fail to successfully complete required training within the allotted extension of time (to include a retest, as appropriate) or should the student fail to meet the requirements in any event, the student will not be permitted to take the Ohio Peace Officer Basic Certification Examination.

Date of Request: _____

Commander Signature: _____

Commander Name: _____

Commander Phone #: _____

Commander Email: _____

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OPOTC INJURY/MEDICAL CONDITION EXAMINATION FORM

Student Name: _____ _____ _____
(Last) (First) (Middle)

School Name: _____

School Number: _____ School Start Date: _____

Commander Name: _____

This section to be completed by MD, DO, PA, or CNP (please type or print legibly)

Examination Date: _____

Diagnosis: _____

_____

_____

_____

Patient Prognosis: _____

_____

_____

_____

Signature of Medical Professional: _____

Title (MD, DO, PA, or CNP): _____ Issuing State: _____ License #: _____

Name: _____

Address: _____

Phone #: _____