



# MIKE DEWINE

★ OHIO ATTORNEY GENERAL ★



Ohio Peace Officer Training Commission  
740-845-2700  
800-346-7682  
Fax 740-845-2675

P.O. Box 309  
London, Ohio 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 licensed physician, 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, they must produce an “OPOTC Medical Release Form,” signed by their physician, 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 they must meet the established requirements in each event. Finally, I have informed the student that, should they fail to successfully complete required training within the allotted extension of time (to include a retest, as appropriate) or should they fail to meet the requirements in any event, they will not be permitted to take the Ohio Peace Officer Basic Certification Examination.

Date of Request: \_\_\_\_\_

Commander Signature: \_\_\_\_\_

Commander Name: \_\_\_\_\_

Commander Phone #: \_\_\_\_\_

Commander Email: \_\_\_\_\_



# MIKE DEWINE

★ OHIO ATTORNEY GENERAL ★



Ohio Peace Officer Training Commission  
740-845-2700  
800-346-7682  
Fax 740-845-2675

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

## 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 attending physician (please type or print legibly)

Examination Date: \_\_\_\_\_

Physician Diagnosis: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Prognosis: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician Signature: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Phone #: \_\_\_\_\_