



For Seasons Pass Refunds Only – *Not for Lift Tickets* Physicians Disability Verification Form

2305 Mt. Werner Circle, Steamboat Springs, CO 80487
Phone: 970-871-5253, Fax: 970-871-5262
Attn: Refund Administrator, Main Ticket Office

The below mentioned patient has requested a refund on their **SKI PASS** due to medical reasons. Please complete this form and return via fax to the Main Ticket Office. This form will not be accepted if hand delivered by the patient. Thank you for your cooperation.

Patient Name: _____

Date of accident or onset of symptoms: _____

Date first examined for this condition: _____

Diagnosis (please explain in as much detail as possible): _____

I verify that my patient's injury is season ending as of...Date: _____

If refund request is for pregnancy, please list date pregnancy was first verified by physician.
Date _____

If season ending date is different from dates of accident and initial examination, please explain below.

Remarks/Additional Comments: _____

Print Physician's Name Physician's Signature License # Date

Address City State Zip Phone Fax

I authorize my physician to release the above information to the Steamboat Ski & Resort Corporation.

Patient Signature _____ Date _____

All information requested above, i.e. date of injury, symptoms, license #, etc., must be completed in order for your patients refund request to be processed. Forms that are not completed properly will be returned to the physician for completion.