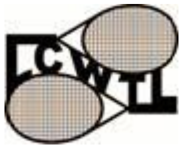

LEE COUNTY WOMEN'S TENNIS LEAGUE

REQUEST FOR MEDICAL APPEAL

Please submit with Attending Physician Notes on letterhead *
to LCWTL Executive Director by October 1
(PLEASE PRINT)

NAME:			
ADDRESS:			
HOME PHONE:		**CELL PHONE:**	
EMAIL:		**CLUB:**	
LAST PLAYED TENNIS:		**DATE:**	
PRESENT RATING:		**RATING REQUESTED:**	
PRESENT TEAMS:		**TEAMS REQUESTED:**	

DETAILS OF MEDICAL CONDITION:	
DESCRIBE SPECIFIC ILLNESS OR ILLNESS :	
ONSET OF ILLNESS/INJURY:	**DATE:**
DESCRIPTION OF SURGERY PERFORMED:	**DATE:**
DESCRIBE TREATMENTS BEING RECEIVED:	
DO YOU EXPECT TO HAVE FULL RECOVERY?	
HAVE YOU BEEN RELEASED TO PLAY TENNIS?	**IF NOT, WHEN?**
OTHER PERTINENT INFORMATION:	

PHYSICIAN INFORMATION:	
PHYSICIAN NAME:	
NAME OF PRACTICE:	**SPECIALTY:**
ADDRESS:	
PHONE:	**FAX:**
PHYSICIAN SIGNATURE:	**DATE:**

COMMITTEE NOTES AND DECISION:

****LCWTL REQUIRES PHYSICIAN NOTES DATED WITHIN THE CURRENT YEAR***