PSIA-AASI Medical Waiver Request Form

2024-2025 Season

TO BE COMPLETED BY MEMBER

Please fill out this form and give to your medical care provider to have them complete the section below.

Member Name_____ Member #_____

Email Address_____ Phone Number_____

Member Signature_____ Date_____

By submitting this form you are acknowledging that you cannot meet the CEU requirements for this 2024-2025 season due to a legitimate medical reason, and therefore are exempt from having to do an on-snow update for this season only.

This information expires June 30, 2025

TO BE COMPLETED BY MEDICAL OFFICE ONLY

Attending Medical Provider _____

Office Address_____

City_____ State_____ Zip_____ Phone Number_____

I have determined that my patient_____ will be or was unable to participate in a one or two day on-snow clinic from _____ to _____ due to injury or illness.

Medical Provider Signature_____ Date_____

Please fax this form to (518) 452-6099

or mail it to:

PSIA-AASI Eastern Region, 5 Columbia Circle, Albany, NY 12203

FOR PSIA-AASI OFFICE USE

Date received _____

Initials _____

Email sent _____