



**For Merchant Pass Refunds Only – *Not for Lift Tickets***

**Physicians Disability Verification Form**

2305 Mt. Werner Circle, Steamboat Springs, CO 80487

Phone: 970-871-5269, Fax: 970-871-5271, Email: TicketVoucher@Steamboat.com

Attn: Merchant Pass Office

The below mentioned patient has requested a refund on their **SKI PASS** due to medical reasons. Please complete this form and return via email or fax. 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.**