COLORADO STATE PATROL
Medical Release Form

I, Dr. _____ do hereby attest and certify to the best of my professional ability that
Licensed Medical Doctor's Printed Name

_____ is not suffering from any physical or mental degenerative disease, including but
Printed Name of Applicant

limited to: Alzheimer's, Dementia, Parkinson's or any other disease that would render them incapable of safely completing a firearms safety course or of safely and competently carrying a firearm.

Name of hospital or health facility: _____

Address: _____

Telephone Number: _____

Date: _____

Licensed Doctor's Signature: _____

Doctor's Printed Name: _____

CSP 31B (05/06)