Special Olympics
New Mexico

Medical Request Form

Name of Requesting Person _____

Delegation _____

Address _____ City _____ Zip _____

Daytime Phone _____ Cell Phone _____

E-Mail _____ Fax _____

Date of Request _____ Area _____

Requested Medicals

Name	Gender	DOB

Your requested medicals will be copied and mailed to the above address within 5 working days of receiving your request. Requests **WILL NOT** be filled 3 weeks prior to any State Competition.