PIEDMONT AUTHORITY FOR REGIONAL TRANSPORTATION
FACE MASK EXEMPTION REQUEST

Please submit this form to request a face mask exemption accommodation due to a medical condition and/or disability. You must submit this form and documentation from your medical provider supplying information on why a face mask exemption is necessary.

All questions must be answered, and signatures are required. Incomplete requests will not be considered. Page 2 is to be completed by a qualified medical professional.

You may hand deliver or mail this form and documentation to **PART, 107 Arrow Road, Greensboro, NC 27409**, send this form and all documentation by email to **contactus@partnc.org** or via fax to **PART** at **336-662-9253**. You may also complete the form online at www.partnc.org/maskexemption. *Please note that if you send this form via email, online, or fax, confidentiality may not be guaranteed.*

Once your request has been approved, you will receive a PART Mask Exemption Card. This card should be shown to the driver prior to boarding any PART Express vehicle. You may also be requested to show this card while at any PART facility.

Today's Date: ___________________________

Name: ____

Address: ____

City, State, Zip: ____

Phone Number: ____

Email Address: ____

Please identify and describe the medical condition and/or disability that is a basis for your request for a mask exemption accommodation by the transit system (Please be specific):

Please describe how a face mask could impact your daily living while riding a transit vehicle or are in a transit facility and why an exemption accommodation is necessary:

Name (PRINT): ____

Signature: ____ Date:__________________

HEALTHCARE PROVIDER VERIFICATION

Information concerning your disability will be treated confidentially. With your permission, information concerning your approved accommodation will be shared with PART staff on a "need to know" basis to provide documentation of your approved accommodation.

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Information below to be filled out by a qualified medical professional:

Patient Name: ____ Date of Birth: __________________

Check One:

_______The above-named individual does not have a medical condition that prevents them from wearing a face mask. This individual **CAN** wear a face mask.

______ The above-named individual **CANNOT** medically tolerate a face-mask due to the following medical conditions (Please provide a detailed description):

Healthcare Provider Organization: ____

Address: ____

Phone Number: ______________________________ Email: ______________________________________

Healthcare Provider Name (PRINT): ____

Title: ____

Signature: ____ Date:___________________________