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:___________________________