**LETTER OF MEDICAL INTOLERANCE**

OF WEARING PROTECTIVE MASK (ORDERING PHYSICIAN/PSYCHIATRIST, PSYCHOLOGIST, OR NURSE PRACTITIONER)

TO WHOM IT MAY CONCERN:

Re: _____ _____

Patient's Name Date of Birth

I, the undersigned, hereby certify that, based on an individual clinical evaluation that I performed on _____, 2020, the above-named patient is unable to medically tolerate the wearing of any type of protective face mask as a COVID-19 preventative measure, and if required to wear a mask, the said patient would be at risk of serious medical harm. I further certify that I am a licensed [Medical Doctor (including Psychiatrist)] [Psychologist] [Nurse Practitioner] (circle one).

_____

Physician's, Psychologist, or Nurse Practitioner's Name Printed

_____ _____

Signature Date