Disability Related Mask Exemption Request

Date of Request: _____

Personal Information

Name: Phone Number:

Address:

City: Zip Code:

Please indicate the nature of your disability and provide a brief description of how your disability prevents you from wearing a mask

Medical Professional Certifying Disability-Related Exemption

Name: Medical License Number:

Title of Medical Professional Certifying Exemption:

Address:

City: Zip Code:

Phone Number:

Statement from Medical Professional Required

Attach a statement signed by your medical professional certifying a disability-related exemption. Statement must be on Medical Professional's letterhead indicating Medical Professional's Name, Title and License Number. Statement must clearly state how the disability prevents you from safely wearing a mask. Exemptions will not be granted based solely on medical diagnosis. Requests for Exemption that do not include a clear explanation of how your disability prevents you from wearing a mask and/or certification from a medical professional will not be processed.

Submitting Disability Related Mask Exemption Request Form & Statement from Medical Professional

Completed requests should be returned to Iris Lawrence via FAX or mail:

- Mailing Address: Iris Lawrence c/o PVTA Mask Exemption Request, 2808 Main Street, Springfield, MA 01107
- PVTA Fax Number: 413-746-1659