## Medical Exemption Form

# Surgical Mask Waiver

I,

……………………………………………………………………………………………………….
Physician Name (all caps / stamp)

Hereby confirm that my patient

| …………………………………………….. | ………………………………………….......... |
| --- | --- |
| Last name / Name | Date of Birth |

Cannot wear a face covering, such as a surgical mask, due to an underlying medical condition.

This document is intended to supplement other required health documents, which may be required for air travel.

| …………………………………………….. | ………………………………………………... |
| --- | --- |
| Location, Date | Physician Signature |