FORM F-9 **Template 9 · How to use**

Template 9: Physician Letter Supporting a Medical Exemption

For a physician or other licensed provider to adapt. Use it only for conditions you have actually diagnosed. It can accompany the state's medical exemption form; it does not replace it.

How to Use This Letter

- A state's form, if it has one, is the controlling document. This letter supplements it.
- Distinguish a contraindication from a precaution and state which applies. See Chapter 16.
- A temporary condition supports a temporary exemption with an end date.
- Disclose only the minimum necessary, and only with the patient's or guardian's written authorization.
- Make sure the provider type is one your state accepts. New York requires a New York-licensed physician; California requires a physician (MD or DO) to file in CAIR-ME; other states differ.

Next: the fill-in sheet (Form F-9) and then the letter follow on the next pages.

BEFORE YOU FILE

Check your state first. Confirm the current form, deadline and filing office with your state or county health department before filing.

In most states this template accompanies an official form and does not replace it. Use your state's current official form wherever one exists, and do not alter it.

Fill in the sheet, print the letter, sign it in ink, keep a copy, and ask for written confirmation that it was received.

FORM F-9 Template 9 · Fill-in sheet

Your answers appear in the letter on the next page automatically.

Complete the fields, then print, sign and file the letter with the documents your state requires.

Fields

Provider's name and credentials	
Practice Name	
Address	
City, State, ZIP Code	
Email Address	
Phone Number	
License Number	
Date	
School, health department or employer	
Patient's Name	
State	
Date of Birth	
Patient pronoun (his, her or their)	
Specific vaccine(s)	
Is / are	
Contraindication, or precaution with risk outweighing benefit	
Diagnosis or history, with dates	
Guidance relied on, and clinical judgment	
Duration (permanent, until a date, or until resolved)	
Records attached or available on request	
State medical exemption form, if required	
Provider's Name, Credentials	

Signature: Date:

FORM F-9 **Template 9 · Letter**

To:

Subject: Medical Exemption Certification for

To Whom It May Concern:

I am a licensed health care provider in and have been treating , date of birth . After evaluating medical history and current health, I have determined that for the following reason:

Diagnosis or history:

Basis in current guidance:

Duration: .

Records supporting this determination are in the patient's chart and . This letter accompanies .

Sincerely,

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