

Medical Exemption Form

(To Be Completed by Medical or Behavioral Health Professional)

Name of Patient: _____

Patient Social Security Number or DHHS ID#: _____

1. What is the person's disabling condition?

2. Can the person engage in employment 30 or more hours per week? Yes No

3. Are there any limitations: No Limitations Limited as follows:

4. How long do you estimate that this individual will be unable to work 30 or more hours per week?

Signature of Medical or Behavioral Professional

Print Name

Date

Address:

Your cooperation is greatly appreciated. Thank you.

Please Return To:

**Maine Department of Health and Human Services
Office of Family Independence
114 Corn Shop Lane
Farmington, ME 04938**