

(Date)

Attn: ND Department of Human Services Medical Division

To Whom This May Concern,

I, (ES Full Name), Employment Specialist at Community Options Inc., would like to request a consideration for Medical Exemption from the JOBS program on behalf of (customer’s full name / case number) for (time period).

(Provide a brief paragraph describing sections stated below)

* Descriptions of medical/psychological issue(s)
* Customer complaints
* Recommendations of health care provider

Attached you will find the following documentation to support the request for medical exemption:

* SFN 451
* Medical Documentation

Please review my submission and consider (customer’s name) for medical exemption.

Sincerely,

Full Name

Title

Community Options, Inc.

Adress

Phone: Ext:

Fax:

Cell: