



Mask Exemption Request

Submit to maskexemption@psfilmfest.org a minimum of 7 days prior to the event date

<i>Initial</i>	<i>This section must be completed by <u>attendee or designated assistant/guardian</u></i>
	Attendee name (<i>print</i>): _____
	Attendee age: _____
	Order confirmation number: _____ Date(s) of event(s): _____ Venue(s): _____
_____	I understand that PSIFS, in its sole discretion and in accordance with CDC/DOT/TSA standards, will determine whether to approve my mask exemption request.
_____	I understand that PSIFS requires that I provide proof of full vaccination.
_____	I understand that PSIFS may require me or my party to move to alternate seats in the auditorium and/or change screening time/date to allow for greater social distancing from other attendees, if possible. PSIFS will advise regarding the alternatives, and changes to screenings or events under these circumstances will be made at no additional cost.
_____	I understand that if PSIFS approves my mask exemption request, I need to print the approval letter and carry it on my person at all times while attending and will need to show it to PSIFS staff upon arrival, and upon request at any time.
_____	I understand that my mask exemption request is applicable only to the event dates and times approved in the letter, and any other exemption will need to be applied for anew.
_____	I authorize the release of medical information pertaining to this mask exemption request and authorize my treating physician to speak with a PSIFS representative or any agent acting on its behalf.
_____	I understand that if I choose to request a mask exemption, PSIFS will use the information on this form to handle my request. In order to assess and manage my request I understand that it may be necessary for PSIFS to disclose information relating to my health information to third parties such as event staff, vendors and their employees, among others.

	<p>INDIVIDUALS LOCATED OUTSIDE OF THE UNITED STATES: If you are located outside of the United States and you choose to request a mask exemption, PSIFS will use the information on this form to handle your request. You understand that this form will be transferred to the United States, where data protection laws may not be equivalent to those in your home country. By signing below and affirmatively submitting this form, you give specific consent to PSIFS to process and transfer the information for these purposes. To exercise rights granted pursuant to applicable law, including withdrawal of consent, contact maskexemption@psfilmfest.org. Withdrawal of consent does not affect the lawfulness of information processed until the withdrawal, and this information will continue to be maintained for compliance with legal obligations and for the establishment, exercise or defense of legal claims.</p>
	<p>Attendee or designated assistant/guardian name (<i>print</i>): _____ Attendee or designated assistant/guardian signature: _____ Date: _____ Phone contact: _____ Email contact: _____</p>

<i>Initial</i>	<p><i>This section must be completed by a <u>medical provider</u> specifically treating the attendee's disability</i></p>
	<p>Patient/Attendee name (<i>print</i>): _____</p>
_____	<p>I am a licensed medical provider currently treating the attendee's disability.</p>
_____	<p>Pursuant to federal law, only individuals with a disability who cannot wear a mask or cannot safely wear a mask because of the disability, for example, individuals who do not know how to remove their masks, cannot remove them on their own, or cannot communicate promptly to ask someone else to remove their mask are eligible to request a mask exemption. Individuals for whom mask wearing may only be difficult are not eligible to request a mask exemption. More details on the CDC order and what qualifies for an exemption can be found here: https://www.cdc.gov/quarantine/masks/mask-travel-guidance.html#disability-exemptions</p> <p>I attest that I have reviewed the CDC disability exemption requirements (link above) and that the attendee qualifies based on a disability as defined by the Americans with Disabilities Act. Additionally, I attest that the attendee cannot safely wear a mask in connection with the screenings and event(s) for the itinerary above for the following reason(s):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

	<hr/> <hr/> <p>Can the attendee wear a face shield? Yes _____ No _____</p>
	<p>Medical provider's license information:</p> <p>Date and type of the license: _____</p> <p>License Number: _____</p> <p>State or other jurisdiction in which license was issued: _____</p>
	<p>Provider name (<i>print</i>): _____</p> <p>Your Specialty: _____</p> <p>Signature and Date: _____</p> <p>Business phone contact: _____</p> <p>Business email contact: _____</p>