

**NEW YORK STATE DEPARTMENT OF CORRECTIONS
AND COMMUNITY SUPERVISION**

**Medical Exemption from Body Scanning
Request Form**

Name: _____ DOB: _____

Address: _____

Request Date: _____ Visitor ID Number: _____
(If known)

Individual(s) Visited:

DIN: _____ Name: _____

DIN: _____ Name: _____

DIN: _____ Name: _____

Expected Duration: _____ to _____ of exemption.

Return this form, along with medical documentation*, to:
BodyScannerMedExemptions@doccs.ny.gov

*Medical documentation **must** include the condition that would be negatively impacted by the body scan and the duration of the limitations (timeframe or lifelong condition). Documentation **must** be signed by your health care provider and include the printed name of the health care provider and the provider's contact information (complete address, phone number, and email address).

DOCCS Use Only:

Exemption Granted (Y/N): _____ Expiration Date: _____

Granted by: _____ Date: _____