



The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health  
250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY  
Governor

KIMBERLEY DRISCOLL  
Lieutenant Governor

MARY A. BECKMAN  
Acting Secretary

MARGRET R. COOKE  
Commissioner

Tel: 617-624-6000  
[www.mass.gov/dph](http://www.mass.gov/dph)

**Request for Accommodation for Medical Incapacity**

Name:  
License No.:  
Docket No.:

I am requesting that the Board consider an accommodation on the basis of my medical incapacity with respect to the requirements I am obligated to fulfill pursuant to the probation of my license.

I am unable to fulfill the requirements of my probation due to the following medical condition(s):

I expect that I will:

- ☐ never be able to return to practice as a result of my condition(s).
- ☐ be able to fulfill the requirements of my probation and return to practice at some point in the future.

**IMPORTANT:** In order for the Board to consider this request, you must provide a letter from your physician that supports your claim of medical incapacity. The letter must include the following information:

- (1) Whether the physician has reviewed the agreement or order that contains the terms of my probation;
- (2) Whether the physician is of the opinion that I am able or unable to fulfill the probation requirements due to one or more medical conditions;
- (3) If the physician is of the opinion that you are unable to fulfill the probation requirements due to one or more medical conditions,
  - a. The diagnosis and prognosis for each such condition;
  - b. Whether you are capable of safely practicing your profession;
  - c. Whether you are expected to recover sufficiently to be able to practice safely and fulfill the requirements of your probation in the future, with an estimated date

**I have supplied a letter from my physician in accordance with the instructions above.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**To submit this form for consideration, please send complete and signed form to your Board of Registration in/of \_\_\_\_\_, Attention: Probation Department.**

**1. Fax: (617) 973 – 0984**

**2. Mail:      Board of Registration in/of \_\_\_\_\_  
                 Probation Department  
                 Bureau of Health Professions Licensure  
                 250 Washington Street  
                 Boston, MA 02108**