To: Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance

Patient: _____

I provide health care services to the above-named patient.

I certify that, in my professional judgment, this patient cannot travel to or participate in a Fair Hearing at the County Department of Social Services without substantial hardship or medical detriment due to this patient's physical and/or mental disabilities.

Provider's Name: _____

Provider's Address: _____

_____

Provider's Telephone No.: (___) _____

Provider's License No.: _____

Provider's Signature: _____

Date Signed: _____