PPW – Exception Request Form

Please fax to: IDPH at 515-281-4535

Date Requested:	Provider Organization:
Client Name:	Provider Staff:
Client Identification Number:	Provider Email:
	Provider Fax:

Describe the exception request and how it supports the client's ***recovery***:
☐ Approved ☐ Denied Notes:

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if applicable)

Provider / Witness Signature: _____ Date: _____

IDPH Signature: _____ Date: _____