LumenMind
PSYCHIATRY
Holistic Mental Wellness

LumenMind Psychiatry, LLC
Pennsylvania Telehealth
215-515-4770
contact@lumenmindpsychiatry.com

School / Work Excuse Request

Demographic Information

Name _____ **Date of Birth** _____

Gender _____ **Phone Number** _____

Address

_____

City _____ **Zip Code** _____ **State** _____

Email

_____

Excuse Request

Reason for request

- ☐ School
- ☐ Work
- ☐ Other (please specify) _____

Duration of excuse **From** _____ **To** _____

To Whom It May Concern (name / title) _____

Addressed to (employer / school name) _____

Additional comments or instructions

Signature

Patient's signature _____ **Date** _____

Please note: completing this form does not guarantee approval of the requested excuse. All excuse requests are subject to review and approval by LumenMind Psychiatry, LLC. Thank you for your cooperation.