[Physician Name/Clinic Name]
[Medical License Number]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

To Whom It May Concern,

Subject: Medical Exemption for Feeding Pump Operation

Patient Name: [Patient Full Name]
Date of Birth: [DOB]

I am the primary healthcare provider for [Patient Name]. This letter serves as a formal medical exemption regarding the operation and management of [Patient Name]'s enteral feeding pump system.

Due to the patient's specific medical diagnosis of [Diagnosis], they require continuous or bolus nutritional support via an electronic feeding pump. This device is a medical necessity for the delivery of life-sustaining nutrition, hydration, and medication.

Please note the following exemptions and requirements for this patient:

- The patient is medically unable to operate the pump independently and requires a trained caregiver for all settings and troubleshooting.
- The feeding pump must remain powered and operational at all times; any interruption in power poses a direct risk to the patient's health.
- The patient is exempt from [Specific Policy/Restriction, e.g., noise ordinances, luggage weight limits, or liquid restrictions] as this equipment and its associated supplies are required for survival.

This medical exemption is [Permanent / Valid until Date].

If you require further clinical verification, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Title/Credentials]