



**Texas Department of State Health Services (DSHS) Tobacco-Free  
Workplace Exemption Request Form**

Date:

DSHS Contracted Agency or Program:

Address of the Work Location:

City:

State:

Zip Code:

DSHS Contract Identification Numbers Located at this Property:

Name of Manager (Point of Contact) Submitting Request:

Phone:

Email:

From the list below, please indicate the barrier/risk that best describes the reason for seeking an exemption to the Tobacco-free Workplace policy at this location:

If Other, please describe:

Please elaborate on the reason selected above for seeking an exemption at this location:



Please describe the desired solution to minimize the barrier(s) or risk(s) described above:

Upon completion, please submit this form for your location and images or documents that help describe the barrier(s) or solution(s) to: [CMUCONTRACTS@DSHS.TX.GOV](mailto:CMUCONTRACTS@DSHS.TX.GOV).

This form must be submitted annually for review and approval by DSHS and be received no later than August 31, 2022.

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**DSHS Decision**

Date Received:

Date Reviewed:

Contract Number:

Approve: \_\_\_\_\_

Disapprove: \_\_\_\_\_

Modify: \_\_\_\_\_