

REQUEST FOR CONTINUING EDUCATION (MEDICAL) WAIVER

Submit to Board prior to Renewal Date

Name: _____ License No(s): _____

With my signature below, I am requesting:

Waiver of ____ continuing education hours for the period April 1, ____ to April 1, ____ for renewal April 1, _____. I have completed ____ hours of attached distance (____ hrs)/supervision (____ hrs) hours.
or

Additional time to complete and document ____ continuing education hours to total the 40 hours required for renewal on April 1, _____. I have completed ____ hours of attached distance (____ hrs) /supervision (____ hrs) hours.
or

To be allowed to document additional supervision hours or distance learning hours as follows to meet the conditions of renewal on April 1, _____. My plan is as follows:_____

Following (or attached) is a summary and chronology of the medical illness/disability that has prevented me from completing the 40 hours of continuing education required for renewal:

My medical condition/situation and the approximate dates, are verified by the attached signed statement(s) from the following medical care provider(s):

I swear/affirm the above is a true and accurate explanation.

Signature of Licensee

Date of Request

Approved:

Waiver of _____ hours

Extension until _____ to document completion of _____ hours that may not be claimed for renewal as of April 1, _____.

Other:_____

Board of Licensed Professional Counselors & Therapists

by_____

Board Member/Representative