OREGON BOARD OF LICENSED PROFESSIONAL COUNSELORS & THERAPISTS

REQUEST FOR CONTINUING EDUCATION
MEDICAL WAIVER

Submit to Board prior to Renewal Date

Name: License No(s):

First renewal date for which waiver is requested:

Estimated period for waiver: from Date to Date

Reason for request:
Include summary and chronology of illness/disability

Attach a statement from medical care provider indicating illness/disability that prevents you from completing continuing education.

Provider's name and title

_____ _____
Signature of Licensee Date of Request

Print, sign, date, and send this form through the mail to:

Board of Licensed Prof. Counselors & Therapists
3218 Pringle Rd SE #250
Salem, OR 97302-6312

OR send a signed copy via electronic mail to lpct.board@state.or.us

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Board of Licensed Professional Counselors & Therapists

_____ _____
Board Member/Representative Date