



WAIVER APPLICATION

Please type or print clearly.

Name:

Last First Middle

Address:

City State Zip

Phone Number: (_____) _____

Date of Birth: _____

License Number: _____

Waiver Type: (check all that apply – Waivers are granted for a 2-year period only):

CONTINUING MEDICAL EDUCATION _____

CONTINUING COMPETENCE _____

Please check the category which most appropriately indicates the reason why you are requesting a waiver.

_____ **Military Service:** When requesting a waiver due to military service, verification of service must be attached.

_____ **Undue Hardship:** Explain and attach verifying documentation as appropriate.

_____ **Health:** Your attending physician must complete and sign the appropriate information requested in the space below by documenting the illness or disability that prevents you from completing the requirements. Use additional paper if needed.

(over)

Describe Illness/Disability: _____

Diagnosis and estimated length of disability: _____

Name of attending physician (print)

License Number

(_____)_____
Phone Number

Address: _____

City

State

Zip

Signature of Attending Physician

Date

-CERTIFICATION-

"I declare under penalty of perjury under the laws of the State of California that the foregoing information contained in this application and my attachments are true and correct to the best of my knowledge."

SIGNATURE

DATE