Request for a Wavier of the CE Requirements

State Board of Sanitarian Registration
77 South High Street, 16th Floor
Columbus, Ohio 43215-6108
Website: http://sanitarian.ohio.gov
E-mail: stephanie.youst@exchange.state.oh.us

Section A **Personal Information**			
First Name:	Middle Name/Initial:	Last Name:	
Mailing Address – Number & Street		City:	
State:	Zip Code:	County:	
Home Telephone w/ Area Code:	E-mail Address (Optional):		RS or SIT Number:
A waiver is based on upon 1.5 hours of continuing education for each month of certified illness or disability. **Explain the reason and/or condition for the request on a separate sheet of paper.**		Amount of Hours You Are Asking To Be Waived:	

I, _____, affirm to the Board that the information provided in this document is true
(Print Name)
and accurate to the best of my knowledge. I understand that this waiver, if granted, is only valid for the period specified by the Board. I have attached a written explanation of my request for a waiver of the continuing education requirements.

_____ _____
Signature *Date*

Section B **Physician Information**		
Physician Name:	License Number and State of Issue:	
Mailing Address – Number & Street (No P.O. Boxes Please):		
City:	State:	Zip Code:
Work Telephone w/ Area Code and Extension:	E-mail Address (optional):	

Section C
To Be Completed By Your Treating Medical Professional(s).

I, _____, affirm to the Board
(Print Name)
that the above mentioned individual was not able to participate in any continuing education activities between _____
(Date)
and _____.
(Date)

_____ _____
Physician Signature *Date*