Ohio | Department of Health

**Mike DeWine**, Governor
**Jon Husted**, Lt.Governor

**Bruce Vanderhoff, MD, MBA**, Director

# Waiver of CE Requirements

****To be completed by registrant****

| **Section A**<br>**Personal Information** | | |
|---|---|---|
| First Name: | Middle Name/Initial: | Last Name: |
| Mailing Address – Number & Street | | City: |
| State: | Zip Code: | EHS or EHSIT Number: |
| Home Telephone w/ Area Code: | E-mail Address: | |
| A waiver is based on upon 1 hour 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 if additional space is required.** | | Number of Hours You Are Asking To Be Waived: |

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

_____ _____
*Signature* *Date*

246 North High Street
Columbus, Ohio 43215 U.S.A.
614 I 466-3543
www.odh.ohio.gov

# Waiver of CE Requirements

***Physician to Complete Information Below****

| **Section B**<br>**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: | |

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

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

_____ _____
*(Physicians Signature)* *(Date)*