STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

REQUEST FOR WAIVER OF PHYSICIAN LICENSE RENEWAL FEE

TO BE COMPLETED BY LICENSEE

I am requesting that my annual physician license renewal fee be waived pursuant to Section 3 of Public Act 07-82.

My signature confirms that I practice medicine at a public health facility (as defined in section 20-126l) or in connection with a mobile health clinic that provided health care services to individuals of this state for no fee for a minimum of 100 hours per year. I do not otherwise engage in the practice of medicine. These conditions will remain unchanged throughout the next registration period. I certify that I have not been convicted of a felony and I have not been disciplined by any other licensing jurisdiction nor am I the subject of a pending investigation or unresolved complaint.

CT Physician License Number: _____

Name on License: _____

Address: _____

City, State, Zip: _____

Daytime Phone Number: (_____) _____ E-mail: _____

_____ _____
Signature Date

Please note: this form must be submitted **annually**.

TO BE COMPLETED BY EMPLOYER

I certify that the above physician has provided a minimum of 100 hours of uncompensated medical care at this facility from _____ to _____.

Name and address of facility: _____

_____

_____

Printed Name of Appropriate Authority: _____

Title: _____

Signature: _____ Date _____

Telephone Number: (_____)_____ Email _____

Your prompt attention to this matter is appreciated, as the renewal process cannot be completed without the above information.

Please return this form directly to: Department of Public Health
Retired Physician License Renewal
410 Capitol Ave., MS# 12MQA
Hartford, CT 06134
Email: oplc.dph@ct.gov