STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF PRACTITIONER LICENSING AND CERTIFICATION
Radiographer
Continuing Education Waiver/Extension Request

License Number: _____ Social Security Number: _____

Last Name: _____ First Name: _____

Address of Record: _____

_____

_____

Application for (Please check one) ☐ Waiver ☐ Extension

I, _____, being duly sworn, declare my eligibility for a waiver/extension of the continuing education requirements:

1. I hereby declare my eligibility for a waiver/extension of the continuing education requirements based on a medical disability/illness pursuant to the provisions of Section 28 of Public Act 06-195. I certify that due to a medical disability/illness, I am unable to complete the continuing education requirements from.

   _____to _____

2. I further declare that I will meet the continuing education requirements as outlined in Section 29 of Public Act 06-195 after the dates indicated above.

3. The above statements are true to the best of my knowledge and belief.

_____ _____

Date Signature

Subscribed and Sworn before me this

_____ day of _____, 20____.

_____

Notary Public

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
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P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

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