



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF PRACTITIONER LICENSING AND CERTIFICATION MESSAGE THERAPIST

Continuing Education Waiver/Extension Request

License 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 20-206f, Connecticut General Statutes. 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 20-206f, Connecticut General Statutes, 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
410 Capitol Avenue – MS # 12MQA
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer