

**APPLICATION FOR CONTINUING EDUCATION
EXTENSION OR EXEMPTION FOR DISABILITY OR ILLNESS**

Department of Inspections, Appeals, & Licensing
Division of Licensing
6200 Park Ave., Des Moines, Iowa 50321 plpublic@idph.iowa.gov

NAME OF APPLICANT: _____
STREET ADDRESS: _____
CITY/STATE/ZIP: _____
NAME OF PROFESSION: _____ **IOWA LICENSE NUMBER:** _____
BIRTH DATE: _____ **SOCIAL SECURITY NUMBER:** _____
AREA CODE/ DAYTIME TELEPHONE NUMBER: _____

- Exemptions are not granted for more than two calendar years.
- This application must be approved prior to renewal, reactivation or reinstatement.
- Side two of this application must be completed by a licensed health professional.
- You will be notified by mail of the decision regarding the application.
- A licensee who obtains approval shall retain a copy of the exemption to be presented to the board upon request.
- This application **does not** exempt a licensee's requirement to pay any fees to maintain an active license.

APPLICATION FOR A CONTINUING EDUCATION: *(select one)*

Exemption to waive all or part of the continuing education requirements Number of hours requested: _____
 Extension of time to complete continuing education requirements Additional time requested in months: _____

TYPE OF APPLICATION: *(complete the appropriate section)*

Personal application. A licensee who has had a physical or mental disability or illness during the license period may apply for an exemption. An exemption provides for an extension of time or exemption from all or part of the continuing education requirements. The application requires the signature of a licensed health professional who can attest to the existence of a disability or illness during the license period.
Approximate beginning date of illness or disability: _____
If known, how long will condition persist? _____
Have you obtained any continuing education within the current biennium? Yes No
If yes, how many hours? _____ You must attach copies of your continuing education documentation.
Describe how your medical condition hindered your ability to obtain continuing education during the current biennium.

Primary caregiver of an ill or disabled relative. If the application is from a licensee who is the primary caregiver for a relative who is ill or disabled and needs care from that primary caregiver, a licensed health professional must verify that the licensee is the primary caregiver.
How you are related to the ill or disabled relative? _____
Approximate beginning date of illness or disability: _____
If known, how long will condition persist? _____
Have you obtained any continuing education within the current biennium? Yes No
If yes, how many hours? _____ You must attach copies of your continuing education documentation
Describe how this situation hindered your ability to obtain continuing education during the current biennium:

Signature of Licensee _____ **Date:** _____

OVER

THIS SECTION MUST BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL

Please check the application type and answer all applicable questions.

The applicant has a diagnosed disability or illness.

Is the applicant currently working? Yes No

If yes, dates(s) applicant was incapacitated: From: _____ To: _____

If no, anticipated date when applicant can return to work: _____

The applicant is the primary caregiver for an ill or disabled relative

Verification that the applicant is the primary caregiver: Yes No

Print the name of the patient or client: _____

State relationship to applicant: _____

Is the applicant currently working? Yes No

If no, anticipated date when applicant can return to work: _____

Answer the questions below regarding the disability or illness of the applicant or relative:

Name of illness/disability: _____

Approximate date the illness or disability began: _____

Describe the disability or illness or attach official documentation: _____

What is the prognosis for the illness or disability? _____

If known, how long will condition persist? _____

Name of health professional: _____

Signature of health professional: _____

Title of health professional: _____

Date: _____

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Biennium Dates: Beginning : _____ End: _____

Approved **Exemption** **Number of Hours waived:** _____

Extension **Hours waived:** _____ **Hours to be earned:** _____ **Date Due:** _____

Disapproved; Reason(s) for disapproval: _____

Request for withdrawal received **Date:** _____

Signature: _____ **Title:** _____ **Date:** _____
