Application & Renewal Bureau
Iowa Department of Inspections, Appeals, & Licensing
6200 Park Avenue, Suite 100 Des Moines, IA 50321-1270
Phone: 515-281-0254 Fax: 515-281-3121
Website: https://dial.iowa.gov/

APPLICATION FOR CONTINUING EDUCATION EXTENSION OR EXEMPTION FOR DISABILITY OR ILLNESS

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 <u>does not</u> 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:**

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: _____

FOR OFFICE USE ONLY							
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:**		

05/2025