

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

IDPH/Bureau of Professional Licensure, Lucas State Office Building - 5th Floor  
Des Moines, Iowa 50319-0075, [www.idph.state.ia.us/licensure](http://www.idph.state.ia.us/licensure)

**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)*

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| <input type="checkbox"/> <b>Personal application.</b> 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.<br><br>Approximate beginning date of illness or disability: _____<br>If known, how long will condition persist? _____<br>Have you obtained any continuing education within the current biennium? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, how many hours? _____ You must attach copies of your continuing education documentation.<br>Describe how your medical condition hindered your ability to obtain continuing education during the current biennium.<br><br>_____<br><br>_____ |
|--|

|   |
|---|
| <input type="checkbox"/> <b>Primary caregiver of an ill or disabled relative.</b> 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.<br><br>How you are related to the ill or disabled relative? _____<br>Approximate beginning date of illness or disability: _____<br>If known, how long will condition persist? _____<br>Have you obtained any continuing education within the current biennium? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, how many hours? _____ You must attach copies of your continuing education documentation<br>Describe how this situation hindered your ability to obtain continuing education during the current biennium:<br><br>_____<br><br>_____ |
| <b>Signature of Licensee</b> _____ <b>Date:</b> _____   |

*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:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

|                        |                          |                   |  |
|------------------------|--------------------------|-------------------|--|
| <b>Biennium Dates:</b> | <b>Beginning :</b> _____ | <b>End:</b> _____ |  |
|------------------------|--------------------------|-------------------|--|

|  |   |                                      |  |
|--|---|--------------------------------------|--|
| <input type="checkbox"/> <b>Approved</b> | <input type="checkbox"/> <b>Exemption</b> | <b>Number of Hours waived:</b> _____ |  |
|--|---|--------------------------------------|--|

|   |                            |                                  |                        |
|---|----------------------------|----------------------------------|------------------------|
| <input type="checkbox"/> <b>Extension</b> | <b>Hours waived:</b> _____ | <b>Hours to be earned:</b> _____ | <b>Date Due:</b> _____ |
|---|----------------------------|----------------------------------|------------------------|

**Disapproved; Reason(s) for disapproval:** \_\_\_\_\_

\_\_\_\_\_

|   |                    |
|---|--------------------|
| <input type="checkbox"/> <b>Request for withdrawal received</b> | <b>Date:</b> _____ |
|---|--------------------|

|                         |                     |                    |
|-------------------------|---------------------|--------------------|
| <b>Signature:</b> _____ | <b>Title:</b> _____ | <b>Date:</b> _____ |
|-------------------------|---------------------|--------------------|

\_\_\_\_\_