REQUEST FOR WAIVER/EXTENSION OF CONTINUING EDUCATION FOR MARRIAGE AND FAMILY THERAPIST LICENSE RENEWAL

LICENSEE INFORMATION			
License No:	License Expiration Date:	Request (check one): _____ Waiver _____Extension of Time	
Licensee Name: First Name	Middle Name/Initial	Last Name	
Mailing Address:			City:
State:	Zip Code:	County:	Daytime Contact Number:
Explanation of Waiver or Extension Request. **Health related waivers or extensions must be supported by a statement from your primary physician explaining the nature of your illness, length of illness, and expected time for recovery.** (Attach Additional Sheets if Necessary):			

I, _____, hereby request ___ a waiver of continuing education
(Print Name)
requirements or ___ an extension of time to complete the continuing education requirements. I attest that my license is currently active and in good standing with the Board. I affirm to the Board that I have read the aforementioned requirements for requesting a waiver of continuing education and extension of time to complete continuing education.

_____ _____
Licensee's Signature Date Signed

FOR BOARD USE ONLY			
☐ **Waiver approved**	☐ **Waiver denied**	☐ **Extension approved**	☐ **Extension denied**
_____ **Board member signature**		_____ **Date**	

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