



WEST VIRGINIA BOARD OF PHYSICAL THERAPY
101 DEE DRIVE
Charleston, West Virginia 25311
Telephone: (304) 558-0367 Fax: (304) 558-0369
www.wvbopt.com

REQUEST FOR WAIVER OF CONTINUING EDUCATION

Last Name:		First Name:	Middle Initial
License No:		License Expiration Date:	
Home Street Address:		City:	
State or Province:	Zip Code:	County:	
Home Phone:	Cell Phone:	Email:	

Explanation of Waiver Request

Health related waivers must be supported by a statement from your treating 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 requirements.
 Print Name

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.

 Licensee's Signature

 Date Signed

OFFICE USE ONLY - DO NOT COMPLETE

DATE RECEIVED	
APPROVED OR DENIED	
COMMENTS	