

**State of CT Department of Public Health
Waiver Application Form for
Continuing Education Training**

**Please note this form is for DPH/HIV Counselor/Educator Certificate of Training only. Use new waiver form for every workshop requesting.*

Name _____

Address _____

City _____ State _____ Zip _____

Telephone () _____ e-mail address _____

Please check off one box for workshop waiver:

- Required Workshop
- Elective Workshop

Check type of certification you are requesting credit for:

- HIV Prevention Counselor Certificate
- HIV AIDS Prevention Educator Certificate

Date of Training _____ (must be within the last three (3) years)

Title of Training _____

Name of Sponsoring Organization _____

Name and qualifications of trainer(s) _____

Number of hours (not including lunch and breaks) – a minimum of six is required _____

Learning Objectives:

1. _____

2. _____

Your description of the course _____

Send or Fax form to: Marianne Buchelli
860-509-7853 or 7855 AIDS and Chronic Diseases Section
Department of Public Health
410 Capitol Ave., MS #11 APV
Hartford, CT 06134-0308

(Attach proof of your attendance and completion (copy of a certification, letter and attendance, etc)