



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF PRACTITIONER LICENSING AND CERTIFICATION PHYSICAL THERAPIST

Continuing Education Waiver/Extension Request

License Number: _____

Last Name: _____ First Name: _____

Address of Record: _____

Application for (Please check one) Waiver Extension

I, _____, being duly sworn, declare my eligibility for a waiver/extension of the continuing education requirements:

1. I hereby declare my eligibility for a waiver/extension of the continuing education requirements based on a medical disability/illness pursuant to the provisions of Section 20-73b(c). I certify that due to a medical disability/illness, I am unable to complete the continuing education requirements from.

_____ to _____

2. I further declare that I will meet the continuing education requirements as outlined in Section 20-73b, Connecticut General Statutes after the dates indicated above.
3. The above statements are true to the best of my knowledge and belief.

Date

Signature

CT PT License Number

Subscribed and Sworn before me this
_____ day of _____, 20____.

Notary Public



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