STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

PHYSICIAN ASSISTANT BOARD
2005 Evergreen Street, Suite 1100, Sacramento, CA 95815
P (916) 561-8780 Fax(916) 263-2671 web www.pac.ca.gov

APPLICATION FOR CONTINUING MEDICAL EDUCATION WAIVER

California Code of Regulations Title 16, Section 1399.618 permits the Physician Assistant Board to exempt a licensee from Continuing Medical Education requirements for a renewal cycle if the licensee cannot meet those requirements for reasons of health, military service, or undue hardship.

Any licensee whose application for a waiver is denied by the Physician Assistant Board is ineligible for active renewal of his or her license unless the licensee complies with the provisions of California Code of Regulations Title 16, Section 1399.615.

NAME (PRINT OR TYPE)	TELEPHONE NUMBER	LICENSE NUMBER PA-	OFFICE USE ONLY _____ Approved _____ Date ___CAS
ADDRESS OF RECORD (CURRENT PUBLIC/MAILING ADDRESS) NUMBER STREET SUITE CITY STATE ZIP CODE			

Reason for Waiver (Check one box only)		Military Service (See Part 1 below)
		Undue Hardship (See Part 2 below)
		Health (See Part 3 below. To be completed by attending physician)

Part 1. MILITARY SERVICE

You must submit proof of your military service. For proof of service, we suggest attaching a copy of your current military orders and a copy of both front and back of your military identification card.

Part 2. UNDUE HARDSHIP

Explain undue hardship reasons here. Attached additional sheets, if necessary. _____

_____

_____

_____

_____

_____

_____

_____

_____

Both pages of this form must be completed.

Part 3. HEALTH

We recommend this form be completed by your attending physician. Please describe the illness and explain how the illness interferes with the licensee's ability to obtain Continuing Medical Education. Attach additional sheets, if necessary. _____

_____

_____

_____

_____

_____

_____

_____

_____

Approximate date illness began: _____ The illness is: Temporary _____ Permanent _____

If temporary, approximate date licensee will be able to continue Continuing Medical Education _____

_____ _____

Attending Physician's Name Telephone Number

Attending Physician's Address:

_____

Number Street Suite City State Zip Code

_____ _____ _____

Attending Physician's Signature Date License Number

I certify under penalty of perjury under the laws of the State of California, that the information contained in this application, including supporting documents, is true and correct and that I am licensed to practice in the State of California.

SIGNATURE ⇨	DATE

NOTICE OF COLLECTION OF PERSONAL INFORMATION: All items in this application are voluntary. Failure to provide any of the requested information however, may delay the processing of your application or result in a denial of the waiver. The information provided will be used to determine your qualifications for licensure and waiver per Section 3524.5 of the California Business and Professions Code and California Code of Regulations Section 1399.618. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Executive Officer is the custodian of records.