Board of Behavioral Sciences
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
Telephone: (916) 574-7830
www.bbs.ca.gov

REQUEST FOR TEMPORARY CONTINUING EDUCATION (CE) WAIVER

VERIFICATION OF DISABILITY OR MEDICAL CONDITION

The board must receive this form with the "Request for Temporary Continuing Education (CE) Waiver – Licensee Application" at least SIXTY (60) DAYS PRIOR TO your license expiration date.

Allow 30 days for processing.

READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

Any unanswered item will cause this request to be incomplete.
Incomplete requests will not be processed.

(Please type or print clearly in ink)

Part 1 - To be Completed by Licensee			
NAME: Last	First	Middle	
TELEPHONE:	EMAIL ADDRESS (OPTIONAL):		
ADDRESS OF RECORD: Number and Street	City	State	Zip Code
LICENSE NUMBER:	CURRENT LICENSE EXPIRATION DATE: _____/_____/_____		

REASON FOR WAIVER REQUEST: (Mark one box only)

☐ **Health – Self:** *(Complete Part 2)*

☐ **Health - Primary Caregiver of Immediate Family Member:** *(Complete Part 3)*

Name of Immediate Family Member: _____

APPLICANT NAME: Last	First	Middle

Part 2 – Health – SELF

To be Completed by Attending Physician/Psychologist

1. What was the individual's diagnosed physical or mental disability or medical condition(s)?

_____

_____

_____

_____

2. Did the condition(s) substantially limit the individual's ability to perform one or more life activities? ☐ Yes ☐ No

3. Approximate date disability/medical condition(s) began: _____

4. Approximate date disability/medical condition(s) resolved, if applicable: _____

Attending Physician's/Psychologist's Name	License Number	Business Telephone	
Attending Physician's/Psychologist's Address	City	State	Zip Code

I declare under penalty of perjury under the laws of the State of California that all the information I have submitted on this form and on any accompanying attachments is true and correct.

_____ _____

Date ***Signature of Physician/Psychologist***

APPLICANT NAME:	Last	First	Middle

Part 3 – Health – LICENSEE'S IMMEDIATE FAMILY MEMBER

Items #1 - 6 to be Completed by Attending Physician/Psychologist of the Family Member

Item #7 to be Completed by the Family Member of the Licensee

1. Immediate Family Member's Name: _____

2. What was the family member's diagnosed physical or mental disability or medical condition(s)?

_____

_____

_____

_____

3. Was the family member unable to work for at least one year as a result of the disability or medical condition(s)? ☐ Yes ☐ No

4. Was the family member unable to perform activities of daily living without substantial assistance for at least one year as a result of the disability or medical condition(s)?
☐ Yes ☐ No

5. Approximate date disability/medical condition(s) began: _____

6. Approximate date disability/medical condition(s) resolved, if applicable: _____

(continued on next page)

APPLICANT NAME: Last	First	Middle

7. The Family Member has provided written authorization below for the release of their protected health information (PHI) for the limited purpose of verification for the Licensee Request for CE Waiver.

I _____ *(insert name of licensee's family member)* voluntarily consent to authorize my healthcare provider to complete this form to disclose my health information during the term of this authorization to the Board of Behavioral Sciences for the specific, limited purpose of verification of my disability or medical condition related to the Licensee Request for CE Waiver.

I authorize the release of my health information that my healthcare provider deems necessary to verify my condition. I also authorize my healthcare provider to release any additional information about my condition, if requested by the Board of Behavioral Sciences, for verification, related to the Licensee Request for CE Waiver.

I understand this authorization will remain in effect until the Board of Behavioral Sciences reviews and either grants or denies the Licensee Request for CE Waiver.

I also understand that my healthcare provider and the Board of Behavioral Sciences cannot guarantee that my health information will not be redisclosed to a third party. The third party may not have to follow the restrictions of this authorization or abide by applicable federal and state law governing the use and disclosure of my health information.

_____
Signature of Licensee's Immediate Family Member

_____
Date

Attending Physician's/Psychologist's Name	License Number	Business Telephone	
Attending Physician's/Psychologist's Address	City	State	Zip Code

I declare under penalty of perjury under the laws of the State of California that all the information I have submitted on this form and on any accompanying attachments is true and correct.

Date	***Signature of Physician/Psychologist***

Notice of Collection of Personal Information

The Board of Behavioral Sciences of the Department of Consumer Affairs collects the personal information requested on this form as authorized by Business and Professions Code sections 4980.54, 4989.34, 4996.22 and 4999.76, and Title 16 California Code of Regulations (CCR) section 1887.2, for the purpose of determining eligibility for a "good cause" wavier of the board's continuing education requirements for the specified renewal period.

Submission of the licensee's personal information, such as name, license number, medical history, and income is mandatory because the Board cannot process the request for the CE waiver without this information. If the licensee requests a CE waiver because they were the primary caregiver for their immediate family member, submission of the family member's personal information, such as name, medical history, name of health care provider, and family member's authorization to release medical information is mandatory because the Board cannot process the request for the CE waiver without this information. The personal information provided is for the limited purpose of evaluating and processing the licensee's request for the CE waiver.

The board makes every effort to protect the personal information provided in this form. However, the information may be disclosed in the following circumstances:

- In response to a Public Records Act request (Government Code Section 6250 and following), as allowed by the Information Practices Act (Civil Code Section 1798 and following);
- To another government agency as required by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant. to another government agency as required by state or federal law; in response to a Public Records

You, and any family member who have provided information on this form, have a right of access to records containing personal information about you maintained by the board, as permitted by the Information Practices Act. For questions about this notice or access to your records, contact the Board at (916) 574-7830 or by email at BBS.info@dca.ca.gov. For questions about the Department of Consumer Affairs' privacy policy or the Information Practices Act, contact the Department of Consumer Affairs, 1625 North Market Blvd., Sacramento, CA 95834 or (800) 952-5210 or email dca@dca.ca.gov.