



**The State of Ohio
Board of Executives of
Long Term Services & Supports**

246 N. High St., 1st Fl
Columbus, OH 43215
Telephone: 614-466-5114
FAX: 614-466-0271
E-mail: dveley@age.ohio.gov

John R. Kasich, Governor • Michael J. Scharfenberger, Chairman • Deborah Veley, Executive Director

Section A – Personal Information			
First Name:	Middle Name/Initial:	Last Name:	
Mailing Address – Number & Street		City:	
State:	Zip Code:	County:	
Home Telephone w/Area Code:	E-mail Address (Optional)	LNHA #	
Amt. of hours requesting to be waived			

I, _____, affirm to the Board that the information
(*Print Name*)
provided in the document is true and accurate to the best of my knowledge. I understand that this waiver, if granted, is only valid for the period specified by the Board. I also understand that I cannot practice as an LNHA until I have fulfilled my CEU requirements and my annual registration has been renewed by the Board. I have attached a written explanation of my request for a waiver of the continuing education requirements.

Signature _____
Date

Section B – Physician Information		
Physician Name:	License Number and state of Issue:	
Mailing Address – Number & Street		
City:	State:	Zip Code:
Work Telephone w/Area Code and Extension:	E-mail Address (Optional)	

Section C – To Be Completed By Your Treating Medical Professional(s).

I, _____, affirm to the Board that the above
(*Print Name*)
mentioned individual was not able to participate in any continuing education activities between

_____ and _____ .
Date *Date*

Physician Signature _____
Date