PODIATRIC MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

APPLICATION FOR WAIVER OF CONTINUING MEDICAL EDUCATION OR CONTINUING COMPETENCE DURING RENEWAL CYCLE

FOR PMBC USE ONLY			
Fee paid:		Receipt #:	
Date Cashiered:		Cashier's Initials:	
Date Approved:		Date Denied:	
Approved Initial:			

To request a waiver for Continuing Medical Education (CME) or Continuing Competence (CC), please fill out the information below and mail it to the address below.

Please print or type. Illegible applications will be returned.

LICENSEE INFORMATION:

LICENSE NUMBER:	E-MAIL/PHONE NUMBER:
DATE OF BIRTH:	EXPIRATION DATE:
NAME:	

The address of record will not be displayed on the Podiatric Medical Board of California's website.

STREET ADDRESS

CITY | STATE | ZIP CODE | COUNTRY

WAIVER TYPE:

Check all that apply – Waivers are granted for a 2-year period only.

☐	Continuing Medical Education (CME)
☐	Continuing Competence (CC)

WAIVER CATEGORY:

Please check the category which most appropriately indicates the reason why you are requesting a waiver.

☐	Military Service	Submit a copy of your current military orders/verification of your Proof of Service or a copy of the front *and* back of your military identification card with this application.
☐	Undue Hardship	Fill out the description below and attach verifying documentation as appropriate.
☐	Health	Your attending physician must complete and sign the appropriate information requested in the space provided describing the illness or disability that prevents you from completing the requirements.

TO BE COMPLETED BY YOUR ATTENDING PHYSICIAN:

Please provide the information as to how undue hardship, illness or disability interferes with the applicant's ability to obtain Continuing Medical Education (CMEs) or Continuing Competence (CCs). Attach additional sheet(s), if necessary.

Description of Undue Hardship/Illness/Disability:

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

If temporary, approximate date applicant will be able to continue his/her CME/CC:

ATTENDING PHYSICIAN INFORMATION:

License Number:	**Phone Number:**

Name:

STREET ADDRESS

CITY STATE ZIP CODE COUNTRY

Attending Physician's Signature (if applicable) Date

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA TO THE TRUTH AND ACCURACY OF THE ABOVE INFORMATION.

Signature Date

Signature and date are required to process this request.

Any physician who submits an application for a CME/CC waiver which is denied by the Board will become ineligible to renew his or her license to practice medicine until such time that the required fees are remitted and satisfactory evidence of completion of the renewal requirements is provided.

If you request an exemption due to military service, please submit "Proof of Service," such as a copy of your current military orders or a copy of both the front and back of your military identification card with this application.

All items in this application are mandatory; none are voluntary. This information is requested by the Licensing Program of the Podiatric Medical Board of California. Failure to provide any of the requested information may result in this application being rejected as incomplete. The information provided will be used to determine your eligibility for waiver of the Continuing Medical Education or Continuing Competence requirements pursuant to Section 1339.678 of Title 16, California Code of Regulations. The Executive Officer is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act by contacting the custodian of records at 2005 Evergreen Street, Suite 1300, Sacramento, CA 95815. Information in this application may be transferred to other governmental and law enforcement agencies.

This form must be mailed to the board at 2005 Evergreen St., Ste. 1300, Sacramento, CA 95815