MEDICAL BOARD OF CALIFORNIA

Licensing Program

APPLICATION FOR WAIVER OF CONTINUING MEDICAL EDUCATION DURING RENEWAL CYCLE

Please print or type. Unsigned and/or Illegible applications will be returned.

FOR OFFICE USE ONLY

Date Received: ____________________

Date Application: Approved: _______ **Denied:** _____

Enforcement Approval: ___**Yes** ___**No Date:**_________

Name (first, middle, last):

Address of Record (current public/mailing address. This is the address that will be displayed on the Medical Board's website. If listing a PO Box, you must also provide a confidential street address.)

Confidential Street Address:

Telephone: ( ) **Fax: ( )**	**E-Mail:**	
Reason for waiver: **(Check one box only.)**	☐	**Military Service (Submit proof of service.)**
	☐	**Undue Hardship (See Part 1 below.)**
	☐	**Health (Part 2 below to be completed by attending physician.)**

California Medical License Number:

Part 1. Undue Hardship. Please provide all information requested below.

Explain undue hardship reason(s) here. Attach additional sheet(s) if necessary.____

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All items in this application are mandatory; none is voluntary. This information is requested by the Licensing Program of the 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 requirements pursuant to Section 1339 of Title 16, California Code of Regulations. The Licensing Program chief 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 1200, Sacramento, CA 95815. Information in this application may be transferred to other governmental and law enforcement agencies.

CME-1W (Revised 11/2015)

BOTH PAGES OF THIS FORM MUST BE COMPLETED.

Part 2. Health. Please provide all information requested below.

Description of illness and explanation as to how the illness interferes with the applicant's ability to obtain Continuing Medical Education. Attach additional sheet(s), if necessary.____

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Approximate date illness began: _________________________ **The illness is: Temporary**______ **Permanent**______

If "temporary," approximate date applicant will be able to continue his/her Continuing Medical Education:_______________________

____ (_____)______________________________
Attending Physician's Name **Telephone Number**

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Attending Physician's Address

____ ____________ ________________
City **State** **Zip**

______________________________________ ______________________________ ________________
Attending Physician's Signature (if applicable) **Date** **License Number**

Part 3. Applicant Signature Required.

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.

____ ______________________________
APPLICANT'S SIGNATURE **Date**

CONTINUING MEDICAL EDUCATION WAIVER INFORMATION AND FILING INSTRUCTIONS

Under Title 16 California Code of Regulations section 1339, the Medical Board of California may exempt a licensee from Continuing Medical Education (CME) requirements for retirement, health, military service, or undue hardship.

Any physician who submits an application for a CME waiver which is denied by the Board will become ineligible to renew his or her license to practice medicine unless the physician complies with the provisions of Section 1338 – Audit and Sanctions for Noncompliance.

IF YOU REQUEST AN EXEMPTION DUE TO MILITARY SERVICE, PLEASE SUBMIT "PROOF OF SERVICE".

For proof of service, please submit a copy of your current military orders or a copy of both the front and back of your military identification card with this application.