

**Board of Registration in Medicine**  
**200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880**  
**Telephone: (781) 876-8210 Fax: (781) 876-8383**  
**www.mass.gov/massmedboard**

**CONTINUING PROFESSIONAL DEVELOPMENT WAIVER REQUEST**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

LICENSE NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

The Board requires that a licensee complete a minimum of 40 hours of continuing professional development credits in Category 1 and 60 credit hours in Category 2 during each renewal cycle, including 10 credits in the area of risk management. A licensee may submit a request for a waiver of the portion of the continuing professional development requirements that the licensee has not completed. A waiver request must be submitted at least 30 days prior to the renewal date. A written statement explaining the reason(s) for requesting a waiver must be submitted and signed under the penalties of perjury.

1. Please explain the reason that you are unable to complete your continuing professional development requirements.

- Prolonged illness     Inaccessibility or unavailability of continuing professional development activities

Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. Please provide a detailed explanation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. How many continuing professional development hours have you completed since your last renewal?

Category 1 \_\_\_\_ Category 2 \_\_\_\_ Risk Management Category 1 \_\_\_\_ Risk Management Category 2 \_\_\_\_

4. Please describe your plan for completing Category 1 and Category 2 continuing professional development requirements. Under the heading type, please use the abbreviation "RM" for risk management credits. Attach additional sheets if necessary.

**CATEGORY 1 CREDITS**

<u>DESCRIPTION OF PROGRAM</u>	<u>TYPE</u>	<u>FROM</u>	<u>TO</u>	<u>CREDIT HOURS</u>
_____	_____	___/___/___	___/___/___	_____
_____	_____	___/___/___	___/___/___	_____
_____	_____	___/___/___	___/___/___	_____
_____	_____	___/___/___	___/___/___	_____
_____	_____	___/___/___	___/___/___	_____
_____	_____	___/___/___	___/___/___	_____
_____	_____	___/___/___	___/___/___	_____
_____	_____	___/___/___	___/___/___	_____
_____	_____	___/___/___	___/___/___	_____

**CATEGORY 2 CREDITS**

<u>DESCRIPTION OF PROGRAM</u>	<u>TYPE</u>	<u>CREDIT HOURS</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I, the undersigned applicant, hereby certify under the penalties of perjury that all information included in this waiver request for continuing professional development constitutes a true statement.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

The Board, in its discretion, may grant a waiver of the continuing professional development requirement. A licensee who receives a waiver is not relieved of any other obligations under M.G.L. c.112 or the regulations issued thereunder. Failure to provide satisfactory documentation of the successful completion of the proposed plan for completion of Category 1 and Category 2 credits will result in revocation of your license to practice medicine.

**RETURN THIS FORM WITH YOUR RENEWAL APPLICATION TO THE RENEWAL DEPARTMENT  
AT THE BOARD OF REGISTRATION IN MEDICINE.**