

WEST VIRGINIA STATE BOARD OF EXAMINERS FOR LICENSED PRACTICAL NURSES
101 DEE DRIVE, SUITE 100
CHARLESTON WV 25311
TELEPHONE: (304) 558-3572 FAX: (304) 558-4367
EMAIL: lpn.board@wv.gov

REQUEST FOR MEDICAL EXEMPTION TO CARE FOR IMMEDIATE FAMILY MEMBER

I, _____, hereby apply for EXEMPTION from employment practice requirement for RENEWAL / REINSTATEMENT of my WV LPN License Number _____. I understand that is granted EXEMPTION from the employment practice requirement, this is ONLY VALID FOR THE CURRENT REPORTING CYCLE, and that I will not be eligible for a medical exemption during any subsequent reporting cycle. I also understand that this exemption will be prorated based on inclusive dates of disability. I further understand that utilization of this medical exemption does not exclude me from any audit of my continuing competence activities, and that the physician named below may be contacted to verify this information.

Signature of Licensee

Date

Social Security Number: XXX-XX-_____

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PHYSICIAN STATEMENT

This certification must be completed by the treating medical doctor, osteopath, chiropractor or podiatrist.

I hereby certify that it/was medically necessary for the above-named individual to be available to care for _____, _____ who is under my professional care and due to these responsibilities is/was unable to fulfill the 400 hour practice requirement for renewal of his/her LPN license.

Nature of Disability: _____

Dates of Disability: Beginning Date: _____ Ending Date: _____

Physician Name (Printed/Typed): _____

PHYSICIAN SIGNATURE

LICENSE NUMBER

DATE

ADDRESS: Street

City

State

Zip

*THIS FORM MUST BE RETURNED TO THE WV LPN BOARD BY THE VERIFYING PHYSICIAN WITH A COPY OF PATIENT'S CURRENT HISTORY AND PHYSICAL.