MHACBO

2209 Lloyd Center, Portland OR 97232

(503)231-8164

mhacbo@mhacbo.org

EXAM WAIVER REQUEST FORM

APPLICANT INFORMATION:

- **Full Name:** _____
- **Date of Birth:** _____
- **Email Address:** _____
- **Phone Number:** _____
- **Certification exam you wish to waive:** _____

EXAM INFORMATION:

- **Exam Name:** _____
- **Governing Body:** _____
- **Exam Abbreviation** _____
- **Date Exam Was Taken:** _____
- **Board for Which Exam Was Taken:** _____

LICENSURE & CREDENTIALING INFORMATION:

Please list all previous behavioral health/healthcare licenses/certifications:

- License/Certification Name: _____
- Governing Board/Organization: _____
- License/Certification Number: _____
- Expiration Date: _____
- License Status: ◯ Active ◯ Expired

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Additional behavioral health/healthcare licenses/certifications:

- License/Certification Name: _____
- Governing Board/Organization: _____
- License/Certification Number: _____
- Expiration Date: _____
- License Status: ◯ Active ◯ Expired

HAVE ANY OF YOUR LICENSES/CERTIFICATIONS EVER BEEN SUSPENDED, REVOKED, OR VOLUNTARILY SURRENDERED?

◯ Yes

◯ No

If yes, please explain:

_____

SUPPORTING DOCUMENTATION:

- Attach a copy of your exam score report or proof of exam completion.
- Attach copies of your active behavioral health licenses/certifications.
- If applicable, provide official documentation regarding any disciplinary actions related to licensure/certifications.

ATTESTATION & SIGNATURE: I HEREBY CERTIFY THAT THE INFORMATION PROVIDED IN THIS EXAM WAIVER REQUEST FORM IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PROVIDING FALSE OR MISLEADING INFORMATION MAY RESULT IN THE DENIAL OF MY REQUEST.

Signature: _____

Date: _____