Virginia Department of Education
Division of Teacher Education and Licensure
Post Office Box 2120
Richmond, VA 23218-2120

REQUEST FOR WAIVER FORM FOR EMERGENCY FIRST AID, CPR INCLUDING HANDS-ON PRACTICE, AND USE OF AEDs REQUIREMENT

This form must be completed when an individual is requesting a waiver from the requirement for initial licensure or renewal of a license set forth by Section 22.1-298.1 of the *Code of Virginia* (effective September 1, 2017). The *Code* states, in part, the following:

> *§ 5. Every person seeking initial licensure or renewal of a license shall provide evidence of completion of certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of automated external defibrillators. The certification or training program shall (i) be based on the current national evidence-based emergency cardiovascular care guidelines for cardiopulmonary resuscitation and the use of an automated external defibrillator, such as a program developed by the American Heart Association or the American Red Cross, and (ii) include hands-on practice of the skills necessary to perform cardiopulmonary resuscitation. The Board shall provide a waiver for this requirement for any person with a disability whose disability prohibits such person from completing the certification or training.*

This request form is for use by an individual with a disability whose disability prohibits such person from completing the certification or training in emergency first aid, cardiopulmonary resuscitation (CPR) including hands-on practice, and the use of automated external defibrillators (AED).

Part I—Information (To be completed by Applicant for a Virginia License or License Renewal)

License or Social Security Number		Date of Birth (Month/Day/Year)
Last Name	First Name	Middle Name
Address (Street, City, State, Zip Code)		
Daytime Telephone Number (include area code)	Home Telephone Number (include area code)	
Disability Prohibiting Completion of Requirement:		

Part II—Applicant's Verification Statement

BY MY SIGNATURE, I VERIFY THAT I HAVE A DISABILITY THAT PROHIBITS ME FROM COMPLETING THE CERTIFICATION OR TRAINING REQUIREMENT (EMERGENCY FIRST AID, CPR INCLUDING HANDS-ON PRACTICE, AND USE OF AEDS) AND THAT THE INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE.

Applicant's Signature_____ Date_____

Part III—Physician's Verification Statement (Part III must be completed by your physician.)

BY MY SIGNATURE, I VERIFY THAT THE ABOVE-NAMED INDIVIDUAL HAS A DISABILITY THAT PROHIBITS THE INDIVIDUAL FROM COMPLETING THE CERTIFICATION OR TRAINING REQUIREMENT (EMERGENCY FIRST AID, CPR INCLUDING HANDS-ON PRACTICE, AND USE OF AEDS).

Physician's Signature_____ Date_____

Physician's Name_____ Office Phone Number _____