



Request for Waiver of First Aid and CPR Training for Personal Care Assistants

Date Submitted: _____

Name of Agency Requesting Waiver:		Provider Number:
Contact Name:		
Phone:	Email:	Fax Number:

As per [7 AAC 125.090. Employment of personal care assistants; qualifications](#) please provide **all** of the following information:
Employee for whom waiver is being requested

Last Name:	First Name:	Hire Date:	Previous CPR/FA certification expiration dates if applicable: CPR First Aid	Town/City of employ/residence:

We request a waiver for the above staff person for the following reasons: (be specific)

(1) medical emergency _____
(2) weather _____
(3) unavailability of classes within 50 miles of the agency's location _____

We request a waiver for the following time period: Start Date: _____ End Date: _____

Our plan for ensuring the employee is in compliance with the training requirements before the expiration of the six month waiver is as follows: (include expected date of completion of training)

Date of expected training _____
Plan: _____

Has a prior waiver been approved? Yes No

If Yes, for what time periods and how much approved waiver time was utilized (period between waiver approval and date of certification)?

Previous Waiver Start Date _____	Previous Waiver End Date _____
(1) medical emergency _____	
(2) weather _____	
(3) unavailability of classes within 50 miles of the agency's location _____	

Completed forms may be e-mailed to DSDESCertification@alaska.gov (preferred) or faxed to (907) 754-3475

This section for SDS Use Only:		
Waiver Approved _____	Waiver Denied _____	Processing Date: _____
Dates Waiver Approved: _____	Dates Waiver Denied: _____	
Approved by: _____	Waiver Denial Reason: _____	
Denied by: _____		

Comments: _____