



## **Licensed HME Services Provider - Continuing Education Waiver Request**

By submitting this request, you are requesting a waiver of one-half of the continuing education contact hours (5 hours/0.5 CEUs) in accordance with rule 4761:1-13-01 of the Ohio Administrative Code.

### **Part 1 - Facility Information**

*To be completed by the owner or authorized representative for the licensed HME services provider.*

Name of Licensed HME Services Provider	License Number
Mailing Address	

### **Part 2 - Affidavit - Notary Public Required**

*To be completed by the owner or authorized representative for the licensed HME services provider.*

**I do solemnly swear or affirm the above named HME services provider receives total payments of not more than ten thousand dollars per year from selling or renting HME.**

Name of Owner or Authorized Representative	Signature of Owner or Authorized Representative
Notary Signature/Commission	Date

NOTARY SEAL/STAMP

