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| --- | --- |
| Staff Use Only | |
| CE Cycle Dates | |
|  |  |

Name Address

Application for Medical Exemption  
Requested Exemption Year:\_\_\_\_

Kentucky Board of Embalmers & Funeral Directors

Complete and file with the Board office by July 1

Age Date

License #

City State Zip Code

Phone Number

Are you presently affiliated with a Funeral Home? Yes No

If yes please list firm.

Reason for exemption

Give a brief explanation of the reason (s) for your request for exemption.

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I agree that if this exemption is granted, I will comply with all statutes and regulations governing the practice of embalming and funeral directing including payment of the annual renewal fee. I understand that if this exemption is granted, it will last until the end of the current CE timeframe. At that time, I will need to reapply if I require another exemption. I swear that the information given on this application is true and correct.

Signature Date

Subscribed and sworn before me by

this the day of 20\_\_\_

My Commission Expires:

Notary Public

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I certify that based upon the above information this license holder was or is unable to participate in any continuing education activity during the compliance period stated above.

Physician's Signature/Date Physician's name printed/License #

Business Phone

Business Address