

Appendix G  
**MHRT/C Course Waiver Request**

**Name of Applicant:** \_\_\_\_\_

**Name of Clinical Supervisor:** \_\_\_\_\_

*The Clinical Supervisor must have provided direct clinical supervision to the applicant during the time frame referenced in this waiver request and must be a Master's level clinician. Acceptable credentials include LCPC, LCSW, APRN, Psychologist, MD/DO, and Psychiatrist. For a complete listing of acceptable credentials, please refer to the MHRT/C Procedural Guidelines.*

**Course Requested for Waiver:** \_\_\_\_\_

*If requesting waivers for more than one course, please use a separate form or letter for each course requested.*

**Dates of Supervision:** \_\_\_\_\_

*Please note that a minimum of one year of work experience is required for each waiver. Each waiver request must have its own specified and distinct time frame. No overlapping of dates and courses is permitted.*

**Please document and describe in detail the work the applicant has performed as well as his or her competencies that relate directly to the course being requested for waiver. Please attach additional page if necessary. Supervisor must sign each additional page.**

*I confirm that I provided direct clinical supervision to the applicant during the time referenced in this waiver request and attest that this individual has acquired the competencies for the course to be waived as listed in the Procedural Guidelines for MHRT/C.*

\_\_\_\_\_  
Signature of Clinical Supervisor

\_\_\_\_\_  
License Type & Number

\_\_\_\_\_  
Date

Please sign, date, and return to applicant. Applicant may submit this form as part of application. For complete requirements regarding waiver requests, please refer to the *Procedural Guidelines for MHRT/C*.