The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
239 Causeway Street, Suite 500, Boston, MA 02114

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MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Request for Extension

Name:
License No.:
Docket No.:

Licensure Condition that is the subject of this request:	**Date originally due**
☐ Submission of proof of completion of continuing education on the topic(s): 1. 2. 3. 4. (If more than 4 continuing education courses, please specify the topic and date due on a separate sheet of paper and submit with this form.) ☐ Submission of proof of completion of continuing education for prior renewal cycles ☐ Submission of CE course descriptions for pre-approval	1. 2. 3. 4.
Obtain employment that will qualify to fulfill the minimum period of supervised professional practice. ☐ I am not currently practicing in my profession but I am actively seeking a job. ☐ I am not currently practicing in my profession and I am currently unable to actively look for work. (Explain below)	**N/A**
☐ Successful completion of examination requirement: ☐ Multistate Pharmacy Jurisprudence Exam ☐ Massachusetts Dental Ethics and Jurisprudence Exam	
☐ Supervisor's submission of verification form or letter	
☐ Supervisor's submission of periodic report	
☐ Evaluation/report from: ☐ Medical provider ☐ Mental health provider	

☐ Submission of proof of compliance with plan of correction	
☐ Submission of updated policies and procedures	
☐ Submission of spore testing results	
☐ Proof of completion of reporting requirements: ☐ Notify other jurisdictions of discipline ☐ Medical Error Report (MER) to ISMP	
☐ Enrollment with DTMC for urine screens	

☐ Other:	

(If more space needed, please write topic and date due on a separate sheet of paper and submit with this form.)

Please explain the reason(s) why you are requesting this extension:

Additional request(s) for extension *may be* allowed. However, such request(s) must be made prior to the expiration date of the previous extension granted.

I understand and agree that as a condition of granting this request, the Board may extend the minimum period during which my license is on a restricted status as necessary to accommodate the request.

_____ _____

Signature Date

To submit this form for consideration, please send complete and signed forms to the attention of Karen Fishman by:

1. **Email (must be a scanned copy with signature appearing on the form):**
   Karen.L.Fishman@MassMail.State.MA.US

2. **Fax: (617) 973 – 0983**

3. **Mail:** **Probation Monitor**
   Bureau of Health Professions Licensure
   239 Causeway Street, 5th floor
   Boston, MA 02114