State of Alaska • Department of Health and Social Service • Senior and Disabilities

SDS Tracking

Request for Waiver of First Aid and CPR Training for Personal Care Assistance Staff

Date:_____

Name of PCA 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 PCA staff person for the following reasons: (be specific)

(1) medical emergency _____

(2) weather _____

(3) unavailability of classes in the community _____

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 in the community _____

Completed forms may be e-mailed to DSDSCertification@alaska.gov (preferred) or faxed to (907) 269-3690

This section for SDS Use Only:

Waiver Approved

Dates Waiver Approved:_____

Approved by:_____

Waiver Denied

Dates Waiver Denied:_____

Waiver Denial Reason:_____

Denied by:_____

Comments:_____