ARKANSAS DEPARTMENT OF HEALTH
VITAL RECORDS
ERAVE ELECTRONIC REGISTRATION PROCESS
WAIVER FORM

Directions: Complete waiver form and sign at the bottom. Email the completed form to ADHERAVE@arkansas.gov, fax the completed form to **501-683-6646**, or mail the completed form to: ATTN: ERAVE, Arkansas Department of Health, 4815 West Markham, Slot 19, Little Rock, AR 72205.

I, ____, hereby state that as a medical certifier in the State of Arkansas, meet one or more of the following requirements to be granted a waiver from submitting records electronically and understand that this form is subject to approval by the Arkansas Department of Health.

Select one or more of the following reasons:

☐ Regularly signs fewer than ten (10) medical certifications (death certificates) per year

☐ Shows other good cause for a waiver as determined by the department in its discretion

Specify____
____
____

Name (Print)____________________________ Title______________________ License# ______________ ______

Signature____ Date___________________________________

Complete Mailing Address and Contact Information

Address/PO Box____

Slot/Suite/Apt/Floor___________________________ City______________________________

State_______________________________________ Zip Code______________________________

Telephone_______________________________ Email Address_______________________________

For State Use Only

☐ APPROVED	☐ DISAPPROVED
By: ______________________________________	Date: __________________________