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

Directions: Complete waiver form and sign at the bottom. Fax completed form to 501-683-6646, or mail 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: _____