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:

☐ Lacks reliable internet connectivity sufficient to ensure access and secure submission to the electronic system

☐ Has not received requested training or technical assistance from the division on the use of the system and correct submission procedure

☐ Regularly signs fewer than five (5) medical certifications (death certificates) per month

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

Specify____

____

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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: ______________________________

VR-200