Department of Health
Military Veteran or Spouse Fee Waiver Request

Submit all the items on the checklist below with your request for fee waiver.

Application Checklist

- ☐ Complete Licensure Application
- ☐ DD-214 or NGB-22
- ☐ Complete Waiver Request

Mail your complete application for licensure, waiver request, and any required fee(s) to:

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330

General Information:

To qualify for this waiver you must be:

- A military veteran who has been honorably discharged within 60 months of submitting this application or;
- A spouse of a military veteran at the time of his/her discharge, who has been honorably discharged within 60 months of submitting this application.

Applicants approved for this waiver will have the initial licensure fee, initial application fee and unlicensed activity fee waived. The waiver may not waive all fees for an application. The fees that may be required to be paid will vary depending on the profession for which you are applying. The waiver does not waive examination fees.

Department of Health
Military Veteran or Spouse Fee Waiver Request

Personal Information:		
Last/Surname First Middle		
License Applying for:	Phone Number:	Email Address:
Mailing Address:		
City	State	Zip Code

Military Veteran Fee Waiver Requirements:
1a. ☐ Yes ☐ No Were you honorably discharged from any branch of the United States Armed Forces in the past 60 months?
1b. Your name at the time of discharge from the United States Armed Forces? _____
1c. Date of your honorable discharge from the United States Armed Forces? _____ MM/YYYY

Spouse of a Military Veteran Fee Waiver Requirements:
2a. ☐ Yes ☐ No Were you a spouse of a member of the United States Armed Forces, at the time of his or her discharge, who has been honorably discharged in the past 60 months?
2b. Name of your spouse referenced in question 2a? _____
2c. Date of your spouse's honorable discharge from the United States Armed Forces? _____ MM/YYYY

Signature:	
Signature:	Date:

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