Department of Health
Military Veteran 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 or who will be honorably discharged within six months of submitting your application or;
- The spouse of a military veteran who has been honorably discharged or who will be honorably discharged within six months of submitting your 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

Complete this section if you are a Military Veteran:
1a. Were you honorably discharged from a branch of the United States Armed Forces or will you be honorably discharged within six months of submitting your application? ☐ Yes ☐ No
1b. What was 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

Complete this section if you are the Spouse of a Military Veteran:
2a. Are you the spouse of a member of the United States Armed Forces who has been honorably discharged or will be honorably discharged within six months of submitting your application? ☐ Yes ☐ No
2b. What was the name of your spouse at the time of discharge? _____
2c. Date of your spouse's honorable discharge from the United States Armed Forces: _____ MM/YYYY

Applicant Signature:	
Signature:	Date: _____ MM/DD/YYYY