State of Illinois
Department of Human Services

REQUEST FOR WAIVER OF DSP TRAINING REQUIREMENTS

Agency Name: _____ Completed by: _____

Date: _____ Title: _____ Phone: _____ E-mail Address: _____

SELECT ONLY ONE WAIVER TYPE PER FORM

☐ Waiver of 30 day requirement to add trained DSP to Health Care Worker Registry

☐ Waiver of 120 day requirement for DSP to complete DSP training

Please detail the reason(s) why employee failed to meet the DSP training program requirements below.

Employee First Name	Employee Last Name	Social Security Number	Hire Date	Still working for Agency? Yes	Still working for Agency? No	Start Date of DSP Training	End Date of DSP Training
				☐	☐		
Reason:							
				☐	☐		
Reason:							
				☐	☐		
Reason:							
				☐	☐		
Reason:							

Return this completed form to:

Illinois Department of Human Services
Division of Developmental Disabilities,
Bureau of Quality Management
600 East Ash Street, Building 400, Mail Stop 2 North
Springfield, IL 62703
Fax: (217) 782-9444
Email address: **DHS.BQM@illinois.gov**