



CONTINUING EDUCATION PROVIDER APPLICATION

Initial Application
 Renewal
 Update

CE PROVIDER NAME: _____

MAILING ADDRESS: _____

PHONE NUMBER: (____) _____ FAX NUMBER: (____) _____

PROGRAM DIRECTOR: _____

EMAIL: _____

CLINICAL DIRECTOR: _____

EMAIL: _____

1. Enclose the resumes of the Program Director and Program Clinical Director with application.
2. Enclose \$300 application fee with application.

TYPE OF ENTITY (CHECK ONE)

- HOSPITAL
- COLLEGE
- OTHER SCHOOL OR TRAINING PROGRAM: _____
- AMBULANCE PROVIDER
- FIRE DEPARTMENT
- LAW ENFORCEMENT AGENCY
- INDIVIDUAL/PRIVATE BUSINESS
- OTHER: _____

I will comply with the attached requirements for CE Providers as set forth in Title 22, Division 9; Chapter 11 of the California Code of Regulations and the San Luis Obispo County CE Provider Guide, and will assure compliance with all regulations, policies, guidelines and procedures required as a CE Provider. I agree to all audit and review provision requirements and certify that all information on this application is true and correct to the best of my knowledge. I understand that failure to comply with CE Regulations and guidelines may result in revocation of my CE approval status.

Program Director Signature: _____ Date: _____

EMSA use only

Completed App. Packet Received	Incomplete - Returned	Approval Date	Expiration Date	CE Provider #:	Fee Paid	Reviewed By
				40-		