Continuing Education Provider Approval Application

1. Continuing Education (CE) Provider Name: _____

2. Phone #: _____ 3. Fax #:_____

4. CE Provider Headquarters:_____
(Number & Street, City, State, Zip)

5. CE Provider Mailing Address: _____
(If different than above)

6. CE Program Director: _____ Email: _____

7. CE Clinical Director: _____ Email: _____

8. CE Provider is a/an: (check one)

- ☐ Local EMS Agency
- ☐ Base Hospital
- ☐ Other Hospital
- ☐ Service Provider Agency
- ☐ EMS Training Program
- ☐ University/College
- ☐ Other School
- ☐ Other Governmental Agency
- ☐ Individual
- ☐ Other CE Provider

9. ATTACH:

   a. Resumes of CE Program Director and Clinical Director, demonstrating individual's experience and qualifications in prehospital care/education

I certify that I have read and understand the "California Prehospital Continuing Education Guidelines," and the Imperial County EMS Agency Policy (#3100) governing continuing education, and that I/this agency will comply with all guidelines, policies, and procedures described therein. I agree to comply with all audit and review provisions described. Furthermore, I certify that all information on this application, and any attachments, to the best of my knowledge, is true and correct.

_____ Date: _____
Signature – CE Program Director

EMS Agency Use

Application Rec'd Date:_____ Reviewed By: _____ Approval Date:_____

Renewal Date _____ CE Provider #: _____ CE Level: BLS ALS Both