

**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.

\_\_\_\_\_  
Signature – CE Program Director

Date: \_\_\_\_\_

EMS Agency Use

Application Rec’d Date: \_\_\_\_\_ Reviewed By: \_\_\_\_\_ Approval Date: \_\_\_\_\_

Renewal Date \_\_\_\_\_ CE Provider #: \_\_\_\_\_ CE Level: BLS ALS Both