

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)

- | | |
|--|--|
| <input type="checkbox"/> Local EMS Agency | <input type="checkbox"/> University/College |
| <input type="checkbox"/> Base Hospital | <input type="checkbox"/> Other School |
| <input type="checkbox"/> Other Hospital | <input type="checkbox"/> Other Governmental Agency |
| <input type="checkbox"/> Service Provider Agency | <input type="checkbox"/> Individual |
| <input type="checkbox"/> EMS Training Program | <input type="checkbox"/> 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