CONTINUING EDUCATION PROVIDER APPLICATION

ORIGINAL MUST BE SUBMITTED.

CE Provider Name	
Address, City, State & Zip Code	
Program Director	
Program Clinical Director	
Primary Contact	
Telephone Number	Email Address

Provider is a(n): *Check One*

- ☐ Local EMS Agency
- ☐ Other Governmental Agency
- ☐ Prehospital Service Provider Agency
- ☐ Hospital
- ☐ Individual
- ☐ EMT Training Program
- ☐ Other School/College/University
- ☐ Other CE Provider
- ☐ CA Statewide Public Safety Agency
- ☐ CE Provider Headquartered in Another State

I certify that I have read and understand the regulations (California Code of Regulation, Title 22, Division 9, Chapter 11, EMS Continuing Education) and that the applicant agency will comply with all regulations described. I agree to comply with all audit and review provisions. Furthermore, I certify that all information on this application, to the best of my knowledge, is true and correct. I understand that failure to comply with the CE regulations may result in revocation of CE approval status.

______________________________ ____________________
Signature of CE Program Director Date

Attach resumes of CE Program Director and Clinical Program Director, which demonstrate their experience and qualifications in pre-hospital care/education as described in the CE regulations.