APPLICATION FOR AUTHORIZATION AS AN APPROVED CONTINUING EDUCATION PROVIDER FOR PREHOSPITAL EMERGENCY MEDICAL SERVICES PERSONNEL

CE Provider Name:	Program Director:
Provider Mailing Address:	Provider Location (if other than mailing address):
Program Clinical Director:	Primary Contact Person:
Phone Number:	Fax Number:
Provider is a/an: (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
Estimated Number of Prehospital CE Courses to be Provided:	

I certify that I have read and understand the regulations (California Code of Regulations, 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 CE Program Director Date

Submit application and fee to the appropriate CE Provider approving authority.
Please Attach:

1. Resume(s) of CE Program Director and Program Clinical Director, which demonstrate individual(s) experience and qualifications in prehospital care/education as described in the CE regulations.
2. Application Fee -- $200 (except statewide public safety agencies)

For local EMS agency or State EMS Authority use only

Application Received Date	Reviewed By	Approval Date	Expiration Date	Provider Number	Comments-Place on Reverse Side	Fee Paid/Date