APPLICATION FOR AUTHORIZATION AS APPROVED PROVIDER OF PREHOSPITAL CONTINUING EDUCATION (CE)

☐ New ☐ Renewal ☐ Update Provider # **30-**_____

CE Program Name	
Mailing Address **Number, Street**	
Suite	
City, State, Zip Code	
Primary Contact Person	
Phone	
Fax	
Email	
CE Program Website	
Program Director **(name, title)**	
Email	
Clinical Director **(name, title)**	
Email	
CE is offered to **(select one)**	☐ employees only ☐ open to the public

PROVIDER IS A/AN: (CHECK ONE)

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

Submit the following:

- ☐ Resumés of CE Program Director and Clinical Director, and the primary instructor if identified
- ☐ Course completion certificate of teaching methodology class (*e.g.,* NAEMSE, CSFM Instructor Course)
- ☐ Sample course completion certificate (CE slip)
- ☐ Sample course roster / sign-in sheet
- ☐ Educational materials from a sample class (*i.e.,* title, overview, objectives, outline, post-test/evaluation)

I certify that I have read and understand the California Emergency Medical Services (EMS) Continuing Education chapter in Title 22 (Division 9, Chapter 11) and OCEMS Policy #530.00 and that this CE provider will comply with all components and requirements described therein. Furthermore, I certify that all information on this application, to the best of my knowledge, is true and correct.

SIGNATURE – _____ *Continuing Education Program Director* Date: _____

This application, with supporting documentation, should be submitted to:

Continuing Education Coordinator
Orange County Emergency Medical Services
405 W. Fifth Street, Suite 301A
Santa Ana, CA 92701
Phone: (714) 834-3500 FAX: (714) 834-3125

OCEMS use only

Application Rec'd Date	Reviewed By	Effective Date	Expiration Date	Provider Number	Provider type CE/Skills/Tng	EMSA notification
				30 –		
Comments						