



APPLICATION FOR AUTHORIZATION AS APPROVED PROVIDER OF PREHOSPITAL CONTINUING EDUCATION IN SAN DIEGO COUNTY

PLEASE PRINT OR TYPE

- 1. PROVIDER/AGENCY NAME: 2. PHONE NO:
3. PROVIDER/AGENCY ADDRESS: STREET & NUMBER CITY STATE ZIP CODE
4. CE Program Director (Full Name/Title/Email address):
CE Program Clinical Director (Full Name/Title/Email address):
5. PROVIDER IS A/AN : (check ONE) 6. Level of CE (Check all that apply)
[] Individual [] BLS
[] Educational Corporation or Group [] ALS
[] Hospital - San Diego County Base Hospital
[] Hospital - Not San Diego County Base Hospital
[] University, College or School
[] Prehospital Provider Agency
[] Other:
7. APPLICATION SUBMITTED BY (Name/Title):
8. Attach:
a. Send a copy of the resume of the CE Program Director and CE Program Clinical Director, demonstrating that individual's experience and qualifications in prehospital care / education.
b. Application fee - \$400.00 / 4 years

I certify that I have read and understand the "Guidelines for Authorized Providers of Prehospital Continuing Education in San Diego County" manual, and that I/this agency will comply with all guidelines, policies, and procedures described therein. I agree to comply with all audit / review provisions described. Furthermore, I certify that all information on this application, to the best of my knowledge, is true and correct.

SIGNATURE - Continuing Education Program Director and/or CE Program Clinical Director or designee

Date:

Submit this application, with appropriate fees and supporting documentation to:

COUNTY OF SAN DIEGO EMERGENCY MEDICAL SERVICES
6255 MISSION GORGE ROAD
SAN DIEGO, CA 92120
(619) 285-6429

(County Use Only)

Table with 7 columns: Application Rec'd, Reviewer, Approval Date, Renewal Date, SD County Authorization Number, Restrictions/Comments, Fee Paid. Row 1: 37-