APPLICATION FOR AUTHORIZATION AS AN 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)
- [ ] Individual
- [ ] Educational Corporation or Group
- [ ] Hospital - San Diego County Base Hospital
- [ ] Hospital - Not San Diego County Base Hospital
- [ ] University, College or School
- [ ] Prehospital Provider Agency
- [ ] Other:_____

6. Level of CE
(Check all that apply)
- [ ] BLS
- [ ] ALS

7. APPLICATION SUBMITTED BY (Name/Title):

8. Attach:
   a. Resume' or Curriculum Vitae and supporting documents of the CE Program Director and CE Clinical Director, demonstrating each individual's experience and qualifications in prehospital care/education per Title-22, Division 9, Chapter 11.
   b. If this is a renewal, provide a brief summary of CE activities that your agency sponsored under the authority of your number, during the previous year of operation.
   c. Application fee - $1,135.00 / 4 years (San Diego Base Hospitals are exempt from this fee)

I certify that I have read and understand the CE Program requirements outlined in Title-22, Division 9, Chapter 11, 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:_____

EMERGENCY MEDICAL SERVICES
San Diego County EMS Office
5510 Overland Avenue, Suite 250
San Diego, CA 92123-1239
MS O-202

(County use only)

Application Rec'd	Reviewer	Approval Date	Renewal Date	San Diego County Authorization Number	Restrictions/Comments	Fee Paid
				37-		