APPLICATION FOR AUTHORIZATION AS APPROVED PROVIDER OF PREHOSPITAL CONTINUING EDUCATION IN SAN DIEGO COUNTY (FY18/19)

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. 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 - $1,135.00 / 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)

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