EMS Continuing Education (CE) Provider Program Application

PROGRAM INFORMATION		
CE Provider/Individual Name:		
CE Provider Number (Renewal Applicants Only):		
Street Address:		
City:	State:	Postal Code:
Telephone Number:	Email Address:	
Program Director Name:		
Clinical Director Name:		

ATTESTATION

I attest that I have reviewed the S-SV EMS Agency EMS CE Provider Approval/Requirements Policy (1001) and will comply with all requirements described therein. I further attest that all information contained in this application and supporting documents is true and correct to the best of my knowledge.

Name _____ Signature _____ Date _____

APPLICATION CHECKLIST

Required Item(s)/Document(s)	Enclosed (Applicant)	Approved (S-SV EMS)
CE Provider Program Application	☐	☐
Program Director Resume, Copy of Applicable Certification/License, & Copies of Applicable Instructor Training Completion Documentation	☐	☐
Clinical Director Resume & Copy of Applicable Certification/License	☐	☐
Sample CE Certificate	☐	☐
CE Program Approval Fee	☐	☐