



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

CE PROVIDER AGENCY NAME: _____

PROVIDER LOCATION: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE # () _____ FAX # () _____

CONTINUING EDUCATION PROGRAM DIRECTOR (FULL NAME / TITLE) _____

EMAIL ADDRESS: _____

CONTINUING EDUCATION CLINICAL DIRECTOR (FULL NAME / TITLE) _____

EMAIL ADDRESS: _____

PROVIDER IS A/AN: (check one)

- Local EMS Agency
Hospital
Prehospital Service Provider Agency
Paramedic Training Program
EMT Training Program
EMR Training Program
Other Governmental Agency (Fire, Law)
Other CE Provider

Estimated Number of CE Hours to be provided:

- ALS Level: _____ Yearly hours
BLS Level: _____ Yearly hours

ATTACH RESUMES of Continuing Education Program Director and Clinical Director, demonstrating that individual's experience and qualifications in prehospital care/education as outlined in Title 22 regulations (copy attached).

I certify that I have read and understand the "California Prehospital Continuing Education Guidelines" and Napa County EMS Agency policies, 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 OF CONTINUING EDUCATION PROGRAM DIRECTOR _____

DATE _____

Submit this completed application, with all supporting documentation to:

Email or Fax your request to:

Napa County EMS Agency
2751 Napa Valley Corporate Drive, Bldg. B
Napa, CA 94558
Office: (707) 253 - 4341
Fax: (707) 299 - 4126
Email: ems@countyofnapa.org

Table with 8 columns: Application Rec'd Date, Reviewed by, Approval Date, Renewal Date, Provider Number, BLS/ALS/Both, Comments, Fee Paid/Date