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 ADDRESS: STREET & NUMBER CITY STATE ZIP CODE

4. PROGRAM DIRECTOR (Full Name/title):
PROGRAM CLINICAL DIRECTOR (Full Name/title):

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:
Title:

8. Attach:
   a. Send a copy of the resume of the Program Director and Program Clinical Coordinator, demonstrating that individual's experience and qualifications are appropriate.
   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 – Program Director or Agency Representative

_____ 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 Received	Reviewer	Approval Date	Renewal Date	County of San Diego Authorization Number	Restrictions/Comments	Fee Paid
				37-		