 **Los Angeles County Emergency Medical Services Agency**

Office of Program Approvals

10100 Pioneer Boulevard, Suite 200

 Santa Fe Springs, CA 90670

(562) 378-1500

**EMS CONTINUING EDUCATION PROVIDER APPLICATION**

**PLEASE PRINT OR TYPE**

CONTINUING EDUCATION PROVIDER PROGRAM NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEADQUARTERS ADDRESS, CITY, STATE, ZIP CODE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS, CITY, STATE, ZIP CODE (IF DIFFERENT THAN ABOVE)

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PROGRAM DIRECTOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLINICAL DIRECTOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As the Program Director of the applicant EMS CE Provider Program, I affirm that I shall:

Initial \_\_\_\_ Provide a **minimum of twelve (12) hours of CE annually**

Initial \_\_\_\_ Notify the EMS Agency of program or personnel change requests within 30 days

Initial \_\_\_\_ Submit all course advertisements/schedules to the EMS Agency a minimum of 14 days prior to the beginning of each course for which the program will issue EMS CE

Initial \_\_\_\_ Ensure each instructor is qualified to present education content

Initial \_\_\_\_ Submit an Annual Summary by January 31st for all courses which the program issued EMS CE for the prior calendar year

SUBMIT all required documents with this application: Review the EMS CE Program Application Checklist

**Note: EMS CE Program communication will be solely addressed with the Program Director**

**As program director for the applicant CE provider, I certify that I will adhere to the above requirements, State of California EMS CE Regulations and all applicable Los Angeles County Prehospital Care policies. Furthermore, I certify that all information on this application and required documents submitted, to the best of my knowledge, is true and correct.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Program Director