



## San Benito County EMS Agency

### APPLICATION FOR AUTHORIZATION AS AN APPROVED CONTINUING EDUCATION PROVIDER FOR PREHOSPITAL EMERGENCY MEDICAL SERVICES PERSONNEL

CE Provider Name:	Program Director:										
Provider Mailing Address:	Provider Location (if other than mailing address):										
Program Clinical Director:	Primary Contact Person:										
Phone Number:	Fax Number:										
Provider is a/an: (Check One) <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Local EMS Agency</td> <td style="width: 50%;"><input type="checkbox"/> EMT Training Program</td> </tr> <tr> <td><input type="checkbox"/> Other Governmental Agency</td> <td><input type="checkbox"/> Other School/College/University</td> </tr> <tr> <td><input type="checkbox"/> Prehospital Service Provider Agency</td> <td><input type="checkbox"/> Other CE Provider</td> </tr> <tr> <td><input type="checkbox"/> Hospital</td> <td><input type="checkbox"/> CA Statewide Public Safety Agency</td> </tr> <tr> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> CE Provider Headquartered in Another State</td> </tr> </table>		<input type="checkbox"/> Local EMS Agency	<input type="checkbox"/> EMT Training Program	<input type="checkbox"/> Other Governmental Agency	<input type="checkbox"/> Other School/College/University	<input type="checkbox"/> Prehospital Service Provider Agency	<input type="checkbox"/> Other CE Provider	<input type="checkbox"/> Hospital	<input type="checkbox"/> CA Statewide Public Safety Agency	<input type="checkbox"/> Individual	<input type="checkbox"/> CE Provider Headquartered in Another State
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Estimated Number of Prehospital CE Courses to be Provided:											

I certify that I have read and understand the regulations (California Code of Regulations, Title 22, Division 9, Chapter 11, EMS Continuing Education) and that the applicant agency will comply with all regulations described. I agree to comply with all audit and review provisions. Furthermore, I certify that all information on this application, to the best of my knowledge, is true and correct. I understand that failure to comply with the CE regulations may result in revocation of CE approval status.

Signature CE Program Director
Date

Submit application to:

San Benito EMS Agency  
 1111 San Felipe Rd., Ste 102, Hollister, CA 95023  
 ph (831) 636-4066 – fax (831) 636-4037

Please attach Resume(s) of CE Program Director and Program Clinical Director, which demonstrate individual(s) experience and qualifications in prehospital care/education as described in the CE regulations.

Application Received Date	Reviewed By	Approval Date	Expiration Date	Provider Number	Comments-Place on Reverse Side	Fee Paid/Date