



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

New     Renewal     Update    Provider # **30-** \_\_\_\_\_ (if applicable)

<b>CE Program Name</b>		
<b>Mailing Address</b>		
	<b>Number, Street</b>	
	<b>Suite</b>	
	<b>City, State, Zip Code</b>	
<b>Primary Contact Person</b>		
<b>Phone</b>		
<b>Fax</b>		
<b>Email</b>		
<b>CE Program Website</b>		
<b>Program Director</b>	<b>(name, title)</b>	
<b>Email</b>		
<b>Clinical Director</b>	<b>(name, title)</b>	
<b>Email</b>		
<b>CE is offered to</b>	<b>(select one)</b>	<input type="checkbox"/> Employees only <input type="checkbox"/> Open to the public
<b>Is CE Provider affiliated with a CPR Training Center?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, write name _____
<b>PROVIDER IS A/AN: (CHECK ONE)</b>		
<input type="checkbox"/> Local EMS Agency	<input type="checkbox"/> Service Provider	<input type="checkbox"/> Other Governmental Agency
<input type="checkbox"/> Base Hospital	<input type="checkbox"/> EMT or EMT-P Training Program	<input type="checkbox"/> Individual
<input type="checkbox"/> Other Hospital	<input type="checkbox"/> University / College	<input type="checkbox"/> Other CE Provider
	<input type="checkbox"/> Other School	

**Submit the following:**

- Résumés of CE Program Director and Clinical Director, and the list of Instructors, if applicable.
- Program Director's course completion certificate of teaching methodology class (e.g., NAEMSE, CSFM Instructor Course)
- Sample course completion certificate (CE slip)
- Statement explaining by which method Continuing Education will be provided
- List of CE courses and method by which they are taught, meeting national standard curriculum as specified in Title 22, Division 9, Chapter 11
- OCEMS established fee (Reference OCEMS Policy #470.00)

\*Additional items may be requested upon review.

**I certify that I have read and understand the California Emergency Medical Services (EMS) Continuing Education chapter in Title 22 (Division 9, Chapter 11) and OCEMS Policy #530.00 and that this CE provider will comply with all components and requirements described therein. Furthermore, I certify that all information on this application, to the best of my knowledge, is true and correct.**

SIGNATURE – \_\_\_\_\_

Continuing Education Program Director

Date: \_\_\_\_\_

**This application, with supporting documentation, should be submitted to:**

Orange County Emergency Medical Services  
405 W. Fifth Street, Suite 301A  
Santa Ana, CA 92701  
Phone: (714) 834-3500 FAX: (714) 834-3125  
[emslicensing@ochca.com](mailto:emslicensing@ochca.com)

OCEMS use only

Application Rec'd Date	Reviewed By	Effective Date	Expiration Date	Provider Number	OCEMS Approval	EMSA notification
<b>Comments</b>						