



**APPLICATION FOR AUTHORIZATION AS EMS APPROVED CONTINUING EDUCATION (CE) PROVIDER**  
**Solano County Emergency Medical Services (EMS) Agency**  
 355 Tuolumne Street, Suite 2400, MS 20-240, Vallejo, CA 94590

**INITIAL:** \_\_\_\_\_ **RENEWAL:** \_\_\_\_\_ **PROGRAM CHANGE:** \_\_\_\_\_

<b>C.E. Provider Name:</b>	<b>Program Director</b>
<b>Provider Mailing Address:</b>	<b>Provider Location (if different than mailing address):</b>
<b>Program Clinical Director (Name):</b>	<b>(Title):</b>
<b>Primary Contact Person (Name):</b>	<b>(Title):</b>
<b>Program Instructor (Name):</b>	<b>(Title):</b>
<b>Phone # (Primary):</b>	<b>Phone # (Alternate):</b>
<b>Fax #</b>	<b>Email:</b>

<b>Provider is (check one):</b>		<b>Provider is (check one):</b>	
Local EMS Agency		EMT Training Program	
Governmental Agency		Other School/College/University	
Prehospital Service Provider Agency		Other CE Provider	
Hospital		CA Statewide Public Safety Agency	
Individual		CE Provider Headquartered in Another State	

Estimated number of Prehospital CE Courses to be provided: \_\_\_\_\_

- REQUIRED DOCUMENTATION:**
- Completed Application;
  - Curriculum Vitae of Program Director, Clinical Director, and Instructors (one individual may perform all these functions). Reference: Solano County EMS Policy 4500, Continuing Education Authorization Policy.
  - In addition to required documentation submitted with this application, approved CE Providers must submit individual course documentation and maintain records as specified in Policy (see Policy 4500, Atch 1).
  - APPLICATION FEE: \$500 (initial and biannual upon renewal of application). Fee waived for public safety agencies offering courses to "in-house" employees only and Solano County ALS Exclusive Ambulance Provider.

I certify that I have read and understand the "California Prehospital Continuing Education Guidelines" and Solano County EMS Policy #4500, and that I/this agency will comply with all guidelines, policies and procedures described therein. I agree to comply with all audit and review provisions described. Furthermore, I certify that all information on this application is true and correct to the best of my knowledge.

_____				_____		
<b>(Signature)</b>				<b>(Date)</b>		
Application Rcvd (Date)	Reviewed By	Approval Date	Expiration Date	Provider #	Comments (on reverse)	Fee paid/date

