SINGLE PROGRAM PROVIDER CONTINUING EDUCATION REQUEST FOR APPROVAL

Board of EMS LSOB 900 SW Jackson, Rm. 1031-S Topeka, KS 66612 785-296-7296

Reset Button

PLEASE TYPE OR PRINT

Sponsoring Organization____

Program Managers Name______________________________Phone #__________________________

Street__________________________City_____________________State_________Zip_______________

Medical Director____

Class Location, Building__________________________Stree_____________________________

City______________________________State_________County_______________EMS Region_______

This program is open to attendants outside of your agency? Yes No

IS THIS CLASS SUBMITTED FOR EDUCATIONAL INCENTIVE GRANT FUNDING? Yes No

Complete the schedule on the back of this form and must be received at least 15 days prior to beginning the continuing education program. If there are any schedule changes necessary, notify BEMS in writing.

THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

________________________________ ________________________

SIGNATURE OF APPLICANT DATE

BEMS USE ONLY

This proposed schedule: ☐ is approved ☐ is not approved

Course Identification Number CIN___________________

Amount of continuing education credit awarded__________

__________________________ _____________________

Approved by Date

DATE	TIME	SUBJECT MATTER	HOURS	INSTRUCTOR QUALIFICATIONS