



CE PROVIDER APPLICATION

MARIN COUNTY EMS AGENCY
 1600 Los Gamos Dr. #220, San Rafael, CA 94903
 ph. 415-473-6871 fax 415-473-3747
 www.MarinEMS.org

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:
Applicant is (check one): <input type="checkbox"/> Local EMS Agency <input type="checkbox"/> EMT -1 Training Program <input type="checkbox"/> Other Governmental Agency <input type="checkbox"/> Other Service Provider Agency <input type="checkbox"/> Other CE Provider <input type="checkbox"/> Hospital <input type="checkbox"/> Individual	
Estimate Number of Prehospital CE Courses to be Provided:	
I hereby 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 as 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 of CE Program Director:	Date:
With your application, please attach the following: Resume(s) of CE Program Director and Program Clinical Director, which demonstrates individual(s) experience and qualifications in prehospital care/education as described in the CE regulations. Submit application and attachments to County of Marin, EMS Agency	

For County of Marin EMS Agency use only:					
Date Received	Reviewed by	Approval Date	Expiration Date	Provider #	Comments on Reverse Side