**CE PROVIDER INFORMATION SHEET**

**PROVIDER NUMBER**

**TELEPHONE**

**PROVIDER NAME**

**CONTACT PERSON**

**ADDRESS**

**CITY**

**STATE** **ZIP**

**OFFICE USE ONLY**

**COURSE #:**

**CONTENT:**

**DISPOSITION:**

**HOURS:**

**REVIEWER:**

**Location of training:** _____________________________________________________________________

**Zip Code:**

**Date(s) of proposed presentation:** _____________________________

**Time:**

**INITIAL DATE**

**THIS FORM MUST BE POSTMARKED NO LATER THAN 30 DAYS PRIOR TO THE INITIAL DATE.**

Title of course: __________________________________________________________________________

Number of continuing education (CE) credits requested (50 minutes of education = 1 hour credit): ____

Criteria for satisfactory completion: Attendance (only if live lecture) _____ or Post-test (attach copy)_____

Instructor’s name & title: __________________________________________________________________

Instructor’s resume/curriculum vitae attached: Yes _____ No_____ On File With DOH: ______________

Course Format: Live lecture ___ or self study ___. If self study, give type: Online, DVD/CD, Other______

Is course approved by ASRT or other CE-approving group? Yes __ No__ (If Yes, attach copy of approval)

**NOTE:** Attach a detailed course outline and description of course objectives to this form. If self-study, submit a copy of the self-study materials for review. If online, provide online access instructions.

**OFFICE USE ONLY**

**Send Materials To:**

**US Postal Mail Address**

**ATTN:** CE COORDINATOR

DOH RADIATION CONTROL

BIN #C21

4052 BALD CYPRESS WAY

TALLAHASSEE, FL 32399-1741

**OVERNIGHT MAIL ADDRESS**

**ATTN:** CE COORDINATOR

DOH RADIATION CONTROL

ROOM 220.01

4042 BALD CYPRESS WAY

TALLAHASSEE, FL 32399

DH Form 374, 10/07 (Replaces previous editions)