CE PROVIDER INFORMATION SHEET

FLORIDA DEPARTMENT OF HEALTH • BUREAU OF RADIATION CONTROL

PROVIDER NUMBER [ ] [ ] [ ] [ ] [ ] [ ] [ ]
(IF KNOWN)

TELEPHONE [ ][ ][ ] [ ][ ][ ] - [ ][ ][ ][ ]

EXTENSION: ____________

______________________________ **(PROVIDER)**

______________________________ **(CONTACT)**

______________________________ **(ADDRESS)**

______________________________ **(CITY/STATE/ZIP)**

OFFICE USE ONLY

RECEIVED: ______________________________

COURSE #: ______________________________

HOURS: ______________________________

CONTENT/DISPOSITION:

EXPIRES: ______________________________

REVIEWER/DATE: ___________/____________

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

E-mail address *(optional)*: ______________________________ *[Under Florida law e-mails are public record.]*

Do you want to be listed on the Department's website as a continuing education (CE) Provider? Yes______ No_______

Location of training: ______________________________

Date(s) of proposed presentation: ______________________________Time: _________________

Title of course: ______________________________

____

Number of continuing education credits requested (30 minutes of education = 0.5 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: If live lecture, attach a detailed course outline and description of course objectives to this form.
If self-study, submit a copy of the self-study materials and post-test for review. If online, provide access instructions.

______________________________ ______________________________
Signature of Applicant/Provider *[print and sign before mailing]* **Date**

SEND MATERIALS TO:

US Postal Mail Address

ATTN: CE COORDINATOR
DOH RADIATION CONTROL
BIN #C21
4052 BALD CYPRESS WAY
TALLAHASSEE, FL 32399-1741

or

Overnight Mail Address

ATTN: CE COORDINATOR
DOH RADIATION CONTROL
ROOM 220.01
4042 BALD CYPRESS WAY
TALLAHASSEE, FL 32399