CE PROVIDER INFORMATION SHEET

BUREAU OF RADIATION CONTROL

PROVIDER NUMBER

(IF KNOWN)

TELEPHONE

Extension: _____

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

Date Application Received:

Course Description: Sufficient_____ Insufficient_____ On File_____

Instructor(s) Vitae: Yes_____ No_____ On File_____

Date Application Reviewed: _____

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