

SINGLE PROGRAM PROVIDER CONTINUING EDUCATION REQUEST FOR APPROVAL

KS BOARD OF EMS

900 SW JACKSON, RM 1031-S

TOPEKA, KS 66612

785-296-7296

PLEASE TYPE OR PRINT

Sponsoring Organization _____ SO Code KS- _____

Program Manager Name _____

Street _____ City _____ State _____ Zip _____

Phone # _____ SS # _____

Medical Advisor _____

Class Location: Bldg _____ Street _____

City _____ State _____ County _____ EMS Region _____

Email: _____

Is this program open to attendants outside of your agency? YES NO

Is this class submitted for Educational Incentive Grant funding? YES NO

Course Dates(s) _____

Course Time(s) _____ # of hours requested _____

Subject Matter for class _____

Primary Instructor _____ Qualifications _____

Other Instructor(s) _____ Qualifications _____

THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I ALSO AGREE THAT SUBMISSION OF THIS FORM TO THE KANSAS BOARD OF EMERGENCY MEDICAL SERVICES ELECTRONICALLY OR BY FACSIMILE WILL HAVE THE SAME FORCE AND EFFECT AS AN ORIGINAL FORM SIGNED BY ME UNDER PENALTY OF PERJURY.

Signature of Program Manager Date

Signature of Medical Advisor Date

KSBEMS USE ONLY

Assigned CIN # _____

Amount of CE credit awarded _____

Reviewed by _____