Print

SAN MATEO COUNTY

DEPARTMENT OF HEALTH SERVICES

EMERGENCY MEDICAL SERVICES AGENCY

801 Gateway Blvd, Ste. 200
South San Francisco, CA 94080
(650) 573-2564

Continuing Education Provider Application

Instructions for Provider Approval

COUNTY OF SAN MATEO
EMERGENCY MEDICAL SERVICES

Check List: Continuing Education Provider Approval

Materials to Be Submitted	Enclosed	EMS Use Only
Application Form		
Program Director Resume or Curriculum Vitae, Information form & Compliance signature		
Program Clinical Director Resume or Curriculum Vitae Information form and Compliance signature		
Instructor Information Form(s) (One for Each Instructor)*** Keep on hand for future use.		

*** No More than Three (3) Students Will Be Assigned to One (1) Individual During Supervised Clinical Experience.

***No More Than Ten (10) Students Will Be Assigned to One (1) Individual During a Skills Practice/Laboratory.

***Occasional instructors may have information kept on file with the CE Provider

CONTINUING EDUCATION PROVIDER

Name of Continuing Education applicant:

_____

Type of entity: _____

Address: Street:_____

City:_____ State:_____ Zip:_____

County:_____ Phone: (___)_____

Website: _____

Level of Continuing Education (check all that apply):

BLS _____ **ALS**_____

Program Director:_____

Contact phone: _____ e-mail: _____

Program Clinical Director:_____

Contact phone:_____ e-mail: _____

Program Contact Person:

_____

Contact phone: _____ e-mail: _____

PERSON WHO PREPARED APPLICATION PACKAGE:

Name:_____

Title:_____

Phone: (____)_____ e-mail: _____

Date submitted:_____

PROGRAM DIRECTOR INFORMATION FORM

CONTINUING EDUCATION PROVIDER

Name:_____

Occupation:_____

Professional and/or Academic Degree(s) held:_____

_____

_____

Professional License Number(s): (if applicable)_____

_____

_____

What teaching credential(s) do you now hold? (if any):

Type:_____ Expiration Date:_____

Type:_____ Expiration Date:_____

As Program Director, I certify I will ensure the continuing education conducted at my site, under the CE provider number issued, will follow what is outlined in the California Code of Regulations,Title 22, Division 9, Chapter 11, 100390-100395 (or most current version when updated). I will direct any questions regarding compliance to the San Mateo County Health Services EMS Division, my accrediting body and agree to an audit review process by the LEMSA during my accreditation period or EMSA as indicated.

_____ _____

Date Signature of Program Director

_____

Printed name

PROGRAM CLINICAL DIRECTOR INFORMATION FORM
CONTINUING EDUCATION PROVIDER

Name: _____

Occupation: _____

Professional and/or Academic Degree(s) held: _____

_____

Professional License Number(s): (if applicable): _____

_____

Instructional Background: (note date completed)

_____ California State Fire Marshal Fire Instructor 1A and 1B

_____ Fire Service Instructional Methodology Course

_____Techniques of Teaching (60 hr)

_____ Four (4) semester units of upper division credit in education materials

_____ Other (please specify and provide details in attachment)

Administrative and/or Management Experience: _____

_____

As Program Clinical Director, I certify I will ensure the continuing education conducted at my site, under the CE provider number issued, will follow what is outlined in the California Code of Regulations, Title 22, Division 9, Chapter 11, 100390-100395 (or most current version when updated). I will direct any questions regarding compliance to the San Mateo County Health Services EMS Division, my accrediting body and agree to an audit review process by the LEMSA during my accreditation period or EMSA as indicated.

_____ _____

Date Signature of Program Clinical Director

_____

Printed name

INSTRUCTOR INFORMATION FORM
CONTINUING EDUCATION PROVIDER
(to be kept on file with the CE provider for each instructor held)

Name:_____

Occupation:_____

Professional and/or Academic Degree(s) held:_____

_____

_____

Professional License Number(s): (if applicable)_____

_____

_____

What teaching credential(s) do you now hold? (if any):

Type:_____ Expiration Date:_____

Type:_____ Expiration Date:_____

Course Content you will teach, by subject:

(Instructors must have "at least one (1) year of experience within the last two (2) years in the specialized area in which they are teaching" or be "knowledgeable, skillful and current in the subject matter of the course or activity".)

_____

_____

_____ is qualified to teach the course material s/he is assigned.

_____ _____

Date Signature of Program Director

HOSPITAL AFFILIATION FORM
CONTINUING EDUCATION PROVIDER

Name(s) of hospital(s) where student instruction (if applicable) is provided:

NAME:_____

STREET:_____

CITY:_____ ZIP:_____

CONTACT PERSON:_____

NAME:_____

STREET:_____

CITY:_____ ZIP:_____

CONTACT PERSON:_____

NAME:_____

STREET:_____

CITY:_____ ZIP:_____

CONTACT PERSON:_____

AMBULANCE AFFILIATION FORM
CONTINUING EDUCATION PROVIDER

Name(s) of ambulance service(s) where student instruction (if applicable) is provided:

NAME:_____

STREET:_____

CITY:_____ ZIP:_____

CONTACT PERSON:_____

NAME:_____

STREET:_____

CITY:_____ ZIP:_____

CONTACT PERSON:_____

NAME:_____

STREET:_____

CITY:_____ ZIP:_____

CONTACT PERSON:_____

CLASS SITE LOCATION FORM
CONTINUING EDUCATION PROVIDER

Please indicate below the address where each Continuing Education program will be offered, if the address is other than at the address shown on the Application Form.

Location: _____

Address: _____

City: _____ Zip: _____

Proposed Dates: _____

Primary Instructor: _____

Other Instructors: _____

SAN MATEO COUNTY EMERGENCY MEDICAL SERVICES

Name of Training Institution:_____

Program Clinical Director _____ Date submitted:_____

EMERGENCY MEDICAL TECHNICIAN-I or EMT- P
NOTIFICATION OF CONTINUING EDUCATION COURSE COMPLETION CERTIFICATES ISSUED

TITLE OF COURSE	DATE OF COURSE COMPLETION	ALS/BLS or both	Method of Instruction	CONTINUING EDUCATION HOURS

The course content shall not include skills which exceed the scope of practice for EMT-I or EMT-P personnel. Keep on hand to submit for renewal process.