



CEU Provider Application

Check the provider categories applying for: (P) | (C) | (H)

This application is for: (check one)

Initial Approval | Renewal - *Previous Provider Number _____

Institution/Provider Name

Address City State Zip

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Business Telephone Fax Number E-Mail

Street Address of Records Keeper City State Zip

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Name of Records Keeper Telephone Number

Application submitted by: Name Title Date

The provider is a/an (check all that apply):

- Association Corporation Government Agency
- Health Facility Individual Partnership
- Licensed DUI Program Private Educ. Inst. Private Practitioner
- University/College Other (Specify) _____

I certify under penalty of perjury, under the laws of the state of California, that the foregoing is true and correct, and that I have read and will abide by the guidelines and instruction stated herein.

Signature Date

.....
For official use only:

Date Received Committee Approved _____ Signature _____ Date _____
Denied _____

Provider Number Assigned _____ CEH's _____

Period of Approval From: _____ To: _____