SACRAMENTO COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF EMERGENCY MEDICAL SERVICES
Continuing Education Provider Approval Program Clinical Director 2B.

(If same as Program Director, complete only name, last section of form and sign.)

CE Provider:

Name:

Address:

Phone: ( )

Occupation:

Present Employer:

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

Professional License Number(s) (must be current and State of California):

Expires:

Expires:

Expires:

Expires:

Expires:

Emergency Care - Related Experience :

Position	Responsibilities	Institution	Dates
(attach resume)			
1.			
2.			
3.			

Emergency Care - Related Education :

Course Title	School	Course Length	Completion Date
1.			
2.			
3.			

Signature/Date:

_____

Program Director

02/09/06