SACRAMENTO COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF EMERGENCY MEDICAL SERVICES
Continuing Education Provider Approval Program Instructor 2C.

(If more than one instructor, fill out one form for each)

(If same as Clinical Director complete name only.)

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:

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.			

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

Type:

Expiration Date:

Signature/Date:

_____

Program Director

02/09/06