

Michigan Department of Health and Human Services Bureau of EMS, Trauma and Preparedness Division of EMS and Trauma P.O. Box 30207 Lansing, MI 48909-0207 517-335-8150 (Phone)

Notification of Intent to MDHHS USE ONLY Received by Regional Coordinator: Date _____ **Conduct a Continuing** Returned for Correction(s): _____ Corrections Received: **Education Topic** Date of Final Review: _____ **EMS CE Program Sponsor** Regional Coordinator Signature: Email application and all required documents to: CE Topic(s) Approval Yes No Region: ___ MDHHS-CE@michigan.gov For use by an EMS CE Program Sponsor that is applying for CE not as part of an initial education program This form must be received by the Department at least 30 days prior to the start of the first class. Failure to complete and submit this form as prescribed may result in an automatic disapproval. Your application and additional documentation will be reviewed and either returned for deficiencies or approved and a copy returned for your records. A copy will also be maintained on file with MDHHS. EMS CE Program Sponsor must provide proof of attendance to each individual and maintain in records, a roster of those individuals who attended each CE session. The CE proof of attendance must have approved category name on the front. For further information, refer to the Standardized EMS CE Credit Guide "Approval Guidelines for Continuing Education Programs" EMS CE Program Sponsor Approval # Sponsor Representative Phone # F-mail: Street Address City State Zip County EMS CE Program Director Phone # E-mail: Name I/C# Street Address IC Licensure Level City State County I affirm that all the information submitted in this notification is true and that all presentations will comply with MDHHS requirements and will occur as outlined in this document. I understand that any misrepresentation of the information provided as part of this notification may result in non-approval or revocation of existing approval, or further action by MDHHS. Signature of EMS CE Program Director C Jan to

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Signature of EMS CE Sponsor Representative____

Date _____

Along with this application, you must attach the following for each class

a. Lesson plan including program content and learning objectives

*CE's requested with initial education require a course schedule in lieu of an outline and objectives

EMS Provider Categories	EMS Provider Categories	Instructor/Coordinator Categories
Preparatory	Special Considerations: Pediatrics: Pt. Assessment	Instructional Techniques
Airway Management and Ventilation	Special Considerations: Pediatrics: Medical	Educational Administration
Patient Assessment	Special Considerations: Pediatrics: Trauma	Measurement & Evaluation
Medical	Special Considerations: Pediatrics: Medication Administration *Required Practical	
Trauma	Operations	
Special Considerations	Operations: Emergency Preparedness	
Special Considerations: Pediatrics:		
Airway		

CONTINUING EDUCATION SCHEDULE

					Number of Credits				
Line	Category Name	Specific Topic Title	Specific Location	Number Hours	MFR/EMR	EMT	AEMT Par	ramedic IC	
Sample	Trauma	Spinal Injury/Backboarding	Name of Business Address Type of facility (agency, hospital, etc).	1	1	1	1	1	O
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Line	Category Name	Specific Topic Title	Specific Location	Number Hours	MFR/EMR	EMT	AEMT	Paramedic	IC
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