



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)

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|---|--|--|--|--|
| <b>Notification of Intent to Conduct a Continuing Education Topic</b><br><b>EMS CE Program Sponsor</b><br>Email application and all required documents to:<br><b><a href="mailto:MDHHS-CE@michigan.gov">MDHHS-CE@michigan.gov</a></b> | <b>MDHHS USE ONLY</b>                        |  |  |  |
|   | Received by Regional Coordinator: Date _____ |  |  |  |
|   | Returned for Correction(s): _____            |  |  |  |
|   | Corrections Received: _____                  |  |  |  |
|   | Date of Final Review: _____                  |  |  |  |
| Regional Coordinator Signature: _____   |  |  |  |  |
| CE Topic(s)    Approval    Yes    No    Region: _____   |  |  |  |  |

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"**

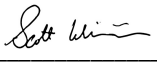
|                        |       |         |            |  |
|------------------------|-------|---------|------------|--|
| EMS CE Program Sponsor |       |         | Approval # |  |
| Sponsor Representative |       | Phone # | E-mail:    |  |
| Street Address         |       |         |            |  |
| City                   | State | Zip     | County     |  |

EMS CE Program Director

|                |       |                    |         |  |
|----------------|-------|--------------------|---------|--|
| Name           |       | Phone #            | E-mail: |  |
| Street Address |       | IC Licensure Level | I/C#    |  |
| City           | State | Zip                | 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  Date \_\_\_\_\_

Signature of EMS CE Sponsor Representative  Date \_\_\_\_\_





