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

CE Provider:

Name:

Address:

Phone: ( )

Occupation:

Present Employer:

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

Professional License Number(s):

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