



**CE PROVIDER INFORMATION SHEET**  
BUREAU OF RADIATION CONTROL

**OFFICE USE ONLY**

PROVIDER NUMBER [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
(IF KNOWN)

TELEPHONE [ ] [ ] [ ] [ ] [ ] [ ] - [ ] [ ] [ ] [ ] [ ] [ ]  
Extension: \_\_\_\_\_

PROVIDER NAME  
CONTACT PERSON  
ADDRESS  
CITY STATE ZIP

COURSE #: \_\_\_\_\_  
CONTENT: \_\_\_\_\_  
DISPOSITION: \_\_\_\_\_  
HOURS: \_\_\_\_\_  
REVIEWER: \_\_\_\_\_

Location of training: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date(s) of proposed presentation: \_\_\_\_\_ Time: \_\_\_\_\_  
(INITIAL DATE)

**THIS FORM MUST BE POSTMARKED NO LATER THAN 30 DAYS PRIOR TO THE INITIAL DATE.**

Title of course: \_\_\_\_\_

Number of continuing education (CE) credits requested (50 minutes of education = 1 hour credit): \_\_\_\_\_

Criteria for satisfactory completion: Attendance (only if live lecture) \_\_\_\_\_ or Post-test (attach copy) \_\_\_\_\_

Instructor's name & title: \_\_\_\_\_

Instructor's resume/curriculum vitae attached: Yes \_\_\_\_\_ No \_\_\_\_\_ On File With DOH: \_\_\_\_\_

Course Format: Live lecture \_\_\_\_\_ or self study \_\_\_\_\_. If self study, give type: Online, DVD/CD, Other \_\_\_\_\_

Is course approved by ASRT or other CE-approving group? Yes \_\_\_ No\_\_ (If Yes, attach copy of approval)

NOTE: Attach a detailed course outline and description of course objectives to this form. If self-study, submit a copy of the self-study materials for review. If online, provide online access instructions.

**OFFICE USE ONLY** Date Application Received: \_\_\_\_\_  
Course Description: Sufficient \_\_\_\_\_ Insufficient \_\_\_\_\_ On File \_\_\_\_\_  
Instructor(s) Vitae: Yes \_\_\_\_\_ No \_\_\_\_\_ On File \_\_\_\_\_  
Date Application Reviewed: \_\_\_\_\_

**SEND MATERIALS TO:** US Postal Mail Address OR Overnight Mail Address  
ATTN: CE COORDINATOR  
DOH RADIATION CONTROL  
BIN #C21  
4052 BALD CYPRESS WAY  
TALLAHASSEE, FL 32399-1741  
ATTN: CE COORDINATOR  
DOH RADIATION CONTROL  
ROOM 220.01  
4042 BALD CYPRESS WAY  
TALLAHASSEE, FL 32399