New Jersey Department of Health #_____

APPLICATION FOR CONTINUING EDUCATION PROGRAM APPROVAL

Mailing Address:
PO Box 358
Trenton, NJ 08625-0358

Overnight Services Only (e.g., UPS, FedEx, DHL):
25 South Stockton Street, 2nd Floor
Trenton, NJ 08608-1832

INSTRUCTIONS: Complete all questions directly on this form. Applications are screened and reviewed by the Department of Health (Department) as they are received. Applications MUST be received by the Department no later than 60 days before the start of the program for which you are requesting approval.

☐*Program announcement/brochure/agenda* ☐*Current reference/source material list* ☐*Material provided to program attendees*
☐*Faculty bio-sketch(es) or resume(s)* ☐*Participant program evaluation form* ☐*Program date(s) and location(s)*

*The Department does not approve programs retroactively. Incomplete applications will **NOT** be reviewed. The Department may be contacted by phone at 609-633-9706.*

*A non-refundable annual application fee (Government agencies are exempt) MUST accompany each application. Please make check payable to "**Treasurer, State of New Jersey**."*

(Check One) ☐*$25 - Less than 3 Hours* ☐*$50 - Three hours or more*

***PROGRAM DATES, TIMES AND LOCATIONS:** The Department is to be notified in writing of any changes, additions, or deletions, before they are implemented, on the Continuation Sheet (page 3) of the Application for Continuing Education Program Approval form.*

GENERAL INFORMATION

1. Name of Sponsoring Agency

2. Street Address

3. City, State, Zip

4. Name of Contact Person for Program	5. Email Address	6. Telephone Number

PROGRAM INFORMATION

7. Title of Program

8. Actual time of program presentation *(exclusive of meals and breaks)*:
Hours: _____ Minutes: _____

9. Fee(s) Charged:
$ _____

10. Type of Program *(check all that apply)*:
☐Workshop ☐Seminar ☐Conference ☐Home Study ☐Printed Material *(attach description)* ☐Audio Media ☐Video Media

11. Target Audience *(check and complete all that apply)*:
☐ LNHA No. of credits requested: _____ ☐CALA No. of credits requested: _____
☐ Program is open to the public ☐ Program is limited to *(specify)*: _____

12. Was this program previously approved by the Department?
☐ No ☐ Yes, for _____ Hours of Credit Approval No.: _____

13. Other state(s) which have approved this program; number of credits granted by each:

14. Is this program currently approved by NAB (NCERS)?
☐ No ☐ Yes, for _____ Hours of Credit Approval No.: _____

15. The references/source material for this program *(attach a current list)* were last evaluated/updated on (date): _____

16. A. Date(s) of Program *(The Department is to be notified in writing of any changes, additions or deletions.)*
Date(s): _____
Location of Program: _____ Room No./Name: _____
Street Address: _____ City: _____ State: _____
Start Time: _____ ☐AM/☐PM End Time: _____ ☐AM/☐PM Phone No. at Location: _____

16. B. Date(s) of Program *(The Department is to be notified in writing of any changes, additions or deletions.)*
Date(s): _____
Location of Program: _____ Room No./Name: _____
Street Address: _____ City: _____ State: _____
Start Time: _____ ☐AM/☐PM End Time: _____ ☐AM/☐PM Phone No. at Location: _____

APPLICATION FOR CONTINUING EDUCATION PROGRAM APPROVAL
(Continued)

Name of Sponsoring Agency	Program Title

17. Program Objectives

18. Brief Description of Program Content

19. Method(s) of Presentation

20. Name(s) of Faculty *(Attach a bio-sketch or resume for each, which includes name, address, phone number, educational/academic background, and work history.)*

21. Method(s) of Program Evaluation *(Attach a copy of the participant program evaluation form.)*

NOTE: A summary of the attendees' evaluations must be received by the Department no later than 30 calendar days after the conclusion of each program. For home study programs, the compilation is to be received in the Department office no later than 30 calendar days after the end of the calendar quarter in which a certificate of completion was issued.

22. Additional Information/Remarks

CERTIFICATION: *Submission of this form constitutes an agreement to comply with the rules and regulations of the New Jersey Department of Health. The Department may audit documentation or make unannounced site visits while a program is in progress. Failure of a sponsor to provide the Department with the documentation upon request or permit access to a program in progress during a site visit or provide a true copy of a program preserved in any format will be considered an immediate termination of the Department's program approval. This may constitute the basis for denial of review and approval for other programs presented by the sponsor at the discretion of the Department.*
I certify that the information provided in this application is true and correct to the best of my knowledge and belief.

23. Submitted by *(Print name)*	24. Submitted by *(Signature)*	25. Date

FOR STATE USE ONLY		
Approved *(approvals are valid for one year)* ☐ Yes ☐ No	Continuing Credit Hours Granted CALA: LNHA:	Program ID Number
Signature		Date

New Jersey Department of Health

APPLICATION FOR CONTINUING EDUCATION PROGRAM APPROVAL (CONTINUATION SHEET) OR NOTIFICATION OF CHANGES, ADDITIONS OR DELETIONS TO CURRENTLY APPROVED PROGRAM(S) AND/OR DATE(S)

Mailing Address:
PO Box 358
Trenton, NJ 08625-0358

Overnight Services Only (e.g., UPS, FedEx, DHL):
25 South Stockton Street, 2nd Floor
Trenton, NJ 08608-1832

***INSTRUCTIONS**:*

1) Use this page as a continuation sheet to list additional dates and locations of currently approved continuing education programs.

2) Use this form to notify the Department of changes, additions or deletions to the dates, locations, faculty, or length of a previously approved program. Programs are approved for one year only. Submission of additional dates, times, and locations does not change the program approval or expiration date. Program approval beyond one year requires the submission of a new application.

Name of Sponsoring Agency	Program Title

A. ☐ This is an additional page of the original program application.

B. ☐ Currently Approved Program *(check all that apply)*:
☐ Change(s) to the current information ☐ Addition(s) to the previously submitted information
N.J. Approval No.: _____

C. ☐ Change(s) ☐ Addition ☐ Deletion(s) *(Check and complete all that apply)*:

Current Information:

Date(s) of Program: _____
Location of Program: _____ Room No./Name: _____
Street Address: _____ City: _____ State: _____
Start Time: _____ ☐AM/☐PM End Time: _____ ☐AM/☐PM Phone No. at Location: _____

New Information:

Date(s) of Program: _____
Location of Program: _____ Room No./Name: _____
Street Address: _____ City: _____ State: _____
Start Time: _____ ☐AM/☐PM End Time: _____ ☐AM/☐PM Phone No. at Location: _____

D. ☐ This is an additional page of the original program application.

E. ☐ Currently Approved Program *(check all that apply)*:
☐ Change(s) to the current information ☐ Addition(s) to the previously submitted information
N.J. Approval No.: _____

F. ☐ Change(s) ☐ Addition ☐ Deletion(s) *(Check and complete all that apply)*:

Current Information:

Date(s) of Program: _____
Location of Program: _____ Room No./Name: _____
Street Address: _____ City: _____ State: _____
Start Time: _____ ☐AM/☐PM End Time: _____ ☐AM/☐PM Phone No. at Location: _____

New Information:

Date(s) of Program: _____
Location of Program: _____ Room No./Name: _____
Street Address: _____ City: _____ State: _____
Start Time: _____ ☐AM/☐PM End Time: _____ ☐AM/☐PM Phone No. at Location: _____

***CERTIFICATION:** Submission of this form constitutes an agreement to comply with the rules and regulations of the New Jersey Department of Health. The Department may audit documentation or make unannounced site visits while a program is in progress. Failure of a sponsor to provide the Department with the documentation upon request or permit access to a program in progress during a site visit or provide a true copy of a program preserved in any format will be considered an immediate termination of the Department's program approval. This may constitute the basis for denial of review and approval for other programs presented by the sponsor at the discretion of the Department.*
I certify that the information provided in this application is true and correct to the best of my knowledge and belief.

G. Submitted by *(Print name)*	**H.** Submitted by *(Signature)*	**I.** Date