



# CONTINUING EDUCATION PROVIDER APPLICATION

**CE Provider No.** \_\_\_\_\_

Type of Application
<input type="checkbox"/> New
<input type="checkbox"/> Renewal
<input type="checkbox"/> Address Change
<input type="checkbox"/> Provider Name Change
<input type="checkbox"/> Coordinator Change

[Please submit this form along with \$150 to the Acupuncture Board. The following must be typewritten or legibly handwritten and in English (C.C.R., Title 16, Division 13.7, Section 1399.481 (a))]

<b>PROVIDER</b>			
_____		_____	
Name of Individual or Organization		Web Address	
<b>ADDRESS</b>			
_____		_____	
Number and Street		City	State Zip
<b>OWNERSHIP</b>		<b>CONTACT #</b>	
_____		_____	
Name of Owner or President		Telephone #	
_____		_____	
E-mail address		Fax #	
<b>CONTACT PERSON</b>		<b>CONTACT #</b>	
_____		_____	
CE Coordinator		Telephone #	
_____		_____	
E-mail address		Fax #	

By signing below, I affirm, under penalty of perjury under the laws of the State of California, that I have read and will comply with the continuing education regulations, and that all statements contained in this application are true and correct.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Title**

**For Acupuncture Board Use Only**

Approved  Renewal Date \_\_\_\_\_

Denied

Evaluator's initials \_\_\_\_\_

FOR BOARD USE ONLY
AMOUNT \$ _____
ATS ID # _____
RECEIPT # _____
CHECK # _____