CHWSD
Community Health Worker
Collaborative of South Dakota

Community Health Worker
Collaborative of South Dakota

P.O. Box 169, Vermillion, SD 57069

Ph: 605-937-9730 E-mail: info@chwsd.org www.chwsd.org

APPLICATION FOR SPONSORSHIP OF CONTINUING EDUCATION PROGRAM

Date: _____

Name of sponsor: _____

Address of sponsor: _____

Name of person responsible for program: _____
(This is where the approval forms will be sent)

Address of person responsible for program: _____

Telephone Number: _____ Fax Number: _____ Email: _____
(Please include area code.)

CE PROGRAM INFORMATION

a. Location: _____

b. Date: _____ Time: _____

c. Title: _____

d. Speaker and affiliation: _____

e. Will certificates of attendance be mailed? _____ Passed out? _____

f. Will file be retained for four years of participant's program completion? _____ Yes _____ No

g. Will sponsor provide to the CHWSD a written list of the CHWs/CHRs attending within 45 days after completion of the program? _____Yes _____ No

h. Number of continuing education contact hours requested: _____

What are the objectives of the continuing education program?

How do you plan to notify the CHWs and CHRs in your general area about this program?

NOTE: *Supplementary materials should be submitted with this form so that the CHWSD can adequately determine number of hours of continuing education credit to be approved.*

SOUTH DAKOTA DEPARTMENT OF HEALTH