



Community Health Worker Collaborative of South Dakota

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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.