Application for Approval as a NEHA Registered Provider

Please use this application to apply to be a NEHA Registered Provider (RP) for the California Dept of Public Health Registered Environmental Health Specialists. Submit the completed application, documentation and fees to NEHA. NEHA defines one continuing education contact hour as equal to one hour of continuing education experience under responsible sponsorship, capable direction and qualified instruction.

STEP 1. Name and Address of Applicant

Contact Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

NEHA Membership Number (if applicable): _____

NEHA Credential Number (if applicable): _____

STEP 2. Program Information

Name of Program: _____

Date(s) of Program: _____

Location of Program: _____

STEP 3. Program Content Summary

Please summarize the content of your program here. Attach an agenda, if available.

STEP 4. Learning Objectives

Please summarize learning objectives of course.

STEP 5. Total CE Hours

Number of Hours attended:* _____

(-)Breaks/Lunches: - _____

(-)Dinners: - _____

(-)Business Meetings: - _____

Total CE = _____

*(subject to revision)

STEP 6. Course Format

Please check the box(s) that most closely describe the program's format.

D Conventional Activities *(check all that apply)*
- D Lectures
- D Workshops
- D Classroom/Field Instruction D Case Presentations

D Self-study Programs *(check all that apply)*
- D Videotape/DVD
- D Audiotape/CD
- D Computer-Based Training
- D Internet Training

D Experiential Skill

D Technical Facility

STEP 7. Instructors

Please list all instructors participating in the program. Attach extra pages if necessary.

Name:_____
Job Title:_____
Employer:_____
Phone Number:_____

Name: _____
Job Title:_____
Employer:_____
Phone Number:_____

Name:_____
Job Title:_____
Employer:_____
Phone Number:_____

Name: _____
Job Title:_____
Employer:_____
Phone Number:_____

STEP 9. Application Fee

There is a $100.00 application fee to be a registered provider.

Method of Payment:

D I have enclosed a check or money order payable to the National Environmental Health Association.

D Please charge my Visa or Mastercard:

Card Number: _____

Exp: _____ CCV (code on back of card):_____

Authorized Signature: _____

Billing Address: _____

_____

STEP 10. SUBMIT FORM TO:

National Environmental Health Association
Dept. #42471
PO Box 650823
Dallas, TX 75265-0823

Phone: 303-756-9090
Fax: 303-691-9490
E-mail: support@neha.org

neha National Environmental Health Association