Central Florida Area Health Education Center
Continuing Education Program
Request Form

Name of Orangization:____

Address:_______________________ City_______________________

State:________ Zip Code:____________ Contact Person:_______________________

Phone Number:____________________ Fax Number:____________________

Type of CE event Requested:_______________________________________

Intended Audience:____

Type of Discipline and estimated number of participants:

_________Physicians (M.D. & D.O.'s)

_________Dieticians and Nutritionists

_________Nurses (A.R.N.P.'s R.N.'s, L.P.N.'s, C.N.A.'s)

_________Dentists or Dental Hygienists

_________Certified Health Education Specialists (C.H.E.S.)

_________Clinical Social Workers, Marriage and Family Therapists and Mental Health Counselors

_________All other non-licensed Health Professionals and Administrative staff

Proposed date of event:____

(Please allow three months planning for CME events and two months planning for all other events)

Requested Location of event:______________________________________

Requested Time of event:____

Requested Instructor(s):____

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