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

_____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)

(CME Credits may not be advertised until you are notified that the program has been approved by the committee)

Requested Location of event:_____

Requested Time of event:_____

Requested Instructor(s):_____

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