

Michigan Department of Licensing and Regulatory Affairs
Corporations, Securities & Commercial Licensing Bureau
Licensing Division
P.O. Box 30018, Lansing, MI 48909
517-241-9288
www.michigan.gov/pss

FOR OFFICE USE ONLY	
Approved By:	
Date Approved:	
License Number	

APPLICATION FOR PROGRAM OR CURRICULUM ADDITION OR DELETION

AUTHORITY: 1943 PA 148
PENALTY: FAILURE TO PROVIDE THIS INFORMATION MAY RESULT IN DENIAL OF THE APPLICATION AND/OR DISCIPLINARY ACTION

School Name		Telephone/E-mail	
Address	City	State	ZIP Code

Contact Name

DELETION OF A PROGRAM - Name of program to be deleted and date of last class.

ADDITION OF A NEW PROGRAM OR CURRICULUM

Enclose the following information:

- Proposed program or new curriculum additions.
- List of equipment supplied by students.
- List of equipment supplied by the school.
- Position description, including job duties, license or certification requirements, and education requirements, for **each** instructional and administrative position related to each of the programs listed.
- Proof of accreditation, if applicable.
- Health Inspection, if applicable.
- Medical Waste Producing Facility Registration, if applicable.

FEE PAYMENT INFORMATION (Check One Box)	FOR OFFICE USE ONLY	FOR OFFICE USE ONLY - VALIDATION
<input type="checkbox"/> Deletion of a Program Fee \$0.00		
<input type="checkbox"/> Addition of a Program Fee \$690.00	8603-01 = \$690.00	
Make your check or money order in U.S. Currency payable to: <p style="text-align: center;">STATE OF MICHIGAN</p>		
FEES ARE AUTHORIZED BY 1943 PA 148		

VERIFICATION AND SIGNATURE

I certify that the statements in this document are true and complete. I understand that any omitted statement, misrepresentation, or fraud may be cause for denial of my application, disciplinary action, or may be punishable by law.

Printed Name and Signature

Date

Sign Below Where Applicable

Programs including Clinicals, Internships or Externships - I hereby attest that the program(s) listed has less than 50% of the program hours dedicated to clinicals, internships or externships. I am aware I must provide the information on who arranges and who supervises the clinical, internship or externship, as well as where it will be held and whether it is paid or unpaid. I am aware that a false statement or dishonest answer may be grounds for denial of my application or disciplinary action against my license, or may be punishable by law.

Signature

Date

Programs Requiring Additional Inspections - I hereby attest that all additional required inspections and registrations have been obtained. I am aware that a false statement or dishonest answer may be grounds for denial of my application or disciplinary action against my license, or may be punishable by law.

Signature

Date

Emergency Medical Services Program (Paramedics, EMT, First Responders) - I hereby attest that the program(s) listed has the joint approval required from the Michigan Department of Community Health. I am aware that a false statement or dishonest answer may be grounds for denial of my application or disciplinary action against my license, or may be punishable by law.

Signature

Date

Nurse Aide or Nursing Programs - I hereby attest that the curriculum for the program(s) listed has the joint approval from the Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Care Services. I am aware that a false statement or dishonest answer may be grounds for denial of my application or disciplinary action against my license, or may be punishable by law.

Signature

Date

Real Estate, Appraisal and Builders Programs - I hereby attest that the curriculum for the program(s) listed has the joint approval required from the Michigan Department of Licensing and Regulatory Affairs, Corporations, Securities & Commercial Licensing Bureau, Licensing Division, Testing & Education Services. I am aware that a false statement or dishonest answer may be grounds for denial of my application or disciplinary action against my license, or may be punishable by law.

Signature

Date

Massage Therapy Program - I hereby attest that the massage therapy curriculum for the program(s) listed is compliant with the administrative rules promulgated by the Board of Massage Therapy and meets the requirements of the rules (R 338.705 and R 338.707). I am aware that a false statement or dishonest answer may be grounds for denial of my application or disciplinary action against my license, or may be punishable by law.

Signature

Date

PROPOSED PROGRAM OR NEW CURRICULUM TO BE OFFERED

COMPLETE FOR EACH PROGRAM BEING OFFERED

Program Title				
	Course Title	Number of Clock Hours of Instruction	Credit Hours (Accredited schools only)	TUITION (do not include books and/or fees)
Course 1				
Course 2				
Course 3				
Course 4				
Course 5				
Course 6				
Course 7				
Course 8				
Course 9				
Course 10				
Course 11				
Course 12				
Course 13				
Course 14				
Course 15				
Course 16				
Course 17				
Course 18				
Course 19				
TOTALS				

Attach additional pages if necessary.