CE Program Sponsor

Name of Program:

Date of Site Visit:

Requirements

Sponsor Type: (School, Hospital, LSA, Military, MCA, Other, Govt.)

Program Sponsor Representative: Statement, Action plan for oversite, Written understanding of responsibilities, Additional contact person

Program Director: Licensed provider and IC, Affiliation or written contract, copy of licenses and resume'

Instructional Faculty: Licensed provider and IC (or SME qualifications), employment agreement/contract, copy of licenses and resume'

Facility Requirements: If virtual, place in Notes column. Facility conducive to learning, sufficient lighting, bathroom facilities, power sources, sufficient lab

Equipment: Enough equipment to adequately accommodate the psychomotor CE class size or skills rotation plan submitted.

AV: If lesson plans for lecture content, must have appropriate AV equipment, such as: computer, screen, speakers.

Operational Policies: Record maintenance (7 years). Students are informed at the session of the approval of program.

Operational Policies: General liability insurance policy, financial support document, ADA policy, non-discrimination policy, sexual harrassment policy.

Consortium Agreements: If applicable, signed agreement, document the location names in Notes column.

Program evaluations: Evaluations will be kept with CE record, and a summary will be written with action plan for changes, as necessary.

Advisory Committee: List of members, meet at least annually, minutes reviewed.

Lesson Plans: Application for CE with previously approved lesson plans and any additional lesson plans to be added.

Certificate of attendance: Current copy of COA with CE Sponsor approval number, signature of approved CE Instructor, Date, Category Title, # of hours.

Summary: Written summary including number of CE classes conducted during approval period, changes made, and other pertinent information.

Attestation and Signatures:

I, the undersigned representatives of the above program, acknowledge receipt of a copy of this site visit report and any supplemental notes. I am aware of the deficiencies listed (if any) and understand that failure to correct the deficiencies will subject the program to administrative action and penalties as outlined in Section 209 of the Michigan Public Health Code and the Administrative Rules thereunder.

Name of CE Program Sponsor Representative Signature Date

Name of CE Program Director Signature Date

I, the undersigned MDHHS representative, acknowledge that I have conducted a full site visit of this program in accordance with the requirements set forth above and that all statements I have made on this site visit report are true and accurate to the best of my knowledge.

MDHHS-BETP Regional Coordinator Name Signature Date

Meets	Notes

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