FOR OFFICE USE
□ Approved □ Denied

Date ________________

Initials ______________

State Office Building Annex
125 Holmes Street, Ste 300
Frankfort, KY 40601
Phone 502-564-7910 Fax 502-696-3806
pharmacy.board@ky.gov

APPLICATION FOR PROVIDER CE APPROVAL

For providers seeking pre-authorization, the application form must be received at least 60 days preceding the presentation. Application form must be submitted within 60 days preceding through 30 days following presentation for approval. Form and supplemental documentation may be mailed, emailed or faxed. Illegible or incomplete submissions will be returned. The board reserves the right to deny approval of any request. The request must be free of commercial bias.

Application Date Submitted _____________ Presentation Date[s] _____________

Name of Provider/Sponsor/Organization/Institution

____

Address ____

Phone Number ____

Email address of Provider/Sponsor ______________________________________

Presenters/CE Coordinators name_______________________________________

Presenter's Address ____

____

____

Presenter's Phone Number ____

Presenter's Email address ____

Please enclose copy of the Presenter's resume/credentials/title.

Name of Continuing Education____

Number of credit hours being requested ___________________________________

List of CE Goals and Objectives (use additional paper if necessary)

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Please include a copy of the power point or a complete handout of the desired program.

Revised June 2018