NEW JERSEY PUBLIC HEALTH CONTINUING EDUCATION PROVIDERSHIP PROGRAM AGREEMENT

By signing this Agreement, the Organization listed below agrees to become a provider of New Jersey public health continuing education contact hours (CEs) and agrees to comply with all policies and procedures of the Providership Program as outlined in the New Jersey Public Health Continuing Education Providership Program Policy and Procedures Manual.

Provider Organization Information

Name of Organization: ____________________

Address: ____________________

____

Designated Primary Administrator

Name: ____________________

Address: ____________________

____

Phone: ____________ Fax: ____________ NJLMN Email: ____________

Chief Officer of the Provider Organization

Name: ____________________

Title: ____________________

Signature: ____________________

Date: ____________________

New Jersey Department of Health

Name: ____________________

Title: ____________________

Signature: ____________________

Date: ____________________

Submit (2) original copies of the signed Agreement to (certified mail recommended):

New Jersey Department of Health
Office of Local Public Health
Public Health Continuing Education Providership Program
PO Box 360
Trenton, NJ 08625-0360

Phone: (609) 984-0363
Fax: (609) 292-4993

Attn: Angela Derry-McKithen

An original copy of the fully executed Agreement will be returned to the Provider Organization for its records.

Planning and Education Coordinators:

List any additional Planning and Education Coordinators who should have access to this Approved Provider Office (attach additional sheets as needed).

Name: ____

Address: ____

____

Phone: ________________ Fax: ____________ NJLMN Email: _____________________

Name: ____

Address: ____

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Phone: ________________ Fax: ____________ NJLMN Email: _____________________

Name: ____

Address: ____

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Phone: ________________ Fax: ____________ NJLMN Email: _____________________

Name: ____

Address: ____

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Phone: ________________ Fax: ____________ NJLMN Email: _____________________