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	**New Jersey Department of Health**
Name: ____________	Name: ____________
Title: ____________	Title: ____________
Signature: ____________	Signature: ____________
Date: ____________	Date: ____________

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

New Jersey Department of Health
Office of Local Public Health, 4th floor
Public Health Continuing Education Providership Program
PO Box 360
Trenton, NJ 08625-0360

Phone: (609) 292-4993

Attn: Jaydeep Nanavaty

(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: ____