



**NDOH CONTINUING EDUCATION PROVIDERSHIP PROGRAM
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 (CE) Contact Hours 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: _____

Email: _____

Phone: _____

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 one(1) original copy of the signed Agreement to: (certified mail recommended):

New Jersey Department of Health
Division of Local Public Health, 5th floor
Public Health Continuing Education Providership Program
PO Box 360
Trenton, NJ 08625-0360
Attn: Olalekan Adigun

Email a copy to dlph.licensure@doh.nj.gov

Phone: (609) 292-4993



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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: _____

Phone: _____ Fax: _____

NJLMN Email: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

NJLMN Email: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

NJLMN Email: _____