

EDUCATIONAL CERTIFICATE REQUEST FORM

A physician licensed in another state who intends to enter into this state for the sole purpose of participating in or providing educational training that involves the provision of patient care must apply for an educational training certificate in order to provide patient care.

Educational training shall include medical education training, conference, clinics, workshops or courses.

PART I – PHYSICIAN INFORMATION

Physician Name: _____ MD DO

Address: _____

City/State/Zip: _____

Current Licensure State: _____

Date License Issued: _____

Expiration Date of License _____

PART II – PROGRAM SPONSOR INFORMATION

Name of Program Sponsor: _____

Program Title: _____

Street Address: _____

City/State/Zip: _____

Name of Responsible Person: _____

Email Address: _____

Telephone Number: _____

Part III – INSTRUCTOR/PROVIDER INFORMATION

Instructor /Provider Name: _____

Credentials: _____

(MD/PHD, LPC, CSW, MSW, etc)

Location of the Course: _____

City/State Zip: _____

Name of the Course: _____

Topics Covered: _____

Sponsor Signature

Date

*If available, attach a copy of the program agenda.