STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
BOARD OF FUNERAL DIRECTORS AND EMBALMERS
500 JAMES ROBERTSON PARKWAY, SECOND FLOOR
NASHVILLE, TENNESSEE 37243-1144
PHONE (615) 741-5062
FAX (615) 532-1903
www.state.tn.us/commerce/boards/funeral

MEMORANDUM

TO: CONTINUING EDUCATION PROVIDERS AND SPONSORS

FR: ROBERT B. GRIBBLE, EXECUTIVE DIRECTOR

RE: CONTINUTING EDUCATION
PROVIDER APPROVAL REQUEST FORM

For your convenience, we have attached the Provider Approval Request Form and information pertaining to its completion. We suggest that you review all of the Continuing Education Rules, giving considerable attention to Chapter 0660-10-.04. It is important to thoroughly follow all instructions.

The following must be received by our office at least sixty (60) days prior to the date of your course:

1) completed Request for Approval form
2) outline of the program/course objectives and daily schedule
3) resume/vitae/biographical sketch of each instructor/speaker

We recommend that you send the above items by overnight express.

Your course will be reviewed and if approved, you will receive an approval letter along with an attendance roster for your convenience, to be completed and returned to our office. Each provider is assigned a Provider Number, and every course is assigned a Course Number. Include these numbers on the attendance roster when sending it to us.

All continuing education courses will be approved only for whole credit hours. Our computer system does not recognize half credits, (i.e. 1.5 CE Hours).

Should you have any questions, do not hesitate to contact our office.

PROVIDER/SPONSOR CONTINUING EDUCATION REQUEST APPROVAL FORM

Program Provider/Sponsor: Name of Contact Person:	Phone: Fax: Email:
Program Provider's Address:	City/State/Zip:
Program Title:	**Number of CE Hours Requested:**_____ (Instructional hours excluding registration time, break and meals. One (1) credit hour equals 50 minutes)
Program Date(s):	Program Location:
Program Description: (A program outline, including times for all portions of the program and any breaks must be attached.)	
Program Objectives:	
Program Instructor(s):	Instructor(s) Company, City, State and Telephone Number:
Instructor's Credentials: (Brief summary or attach resume'/vitae/bio for each)	

Attendance certified by: ☐ Sponsor ☐ Instructor ☐ Other: _____

Certifier's Name and Address: _____

_____

Describe method of attendance monitoring:

Is this course/program approved for C.E. credit by the Academy of Professional Funeral Service Practice or another licensing/professional organization? ☐ Yes ☐ No

If yes, who? _____ (attach documentation)

Will this program be open to all licensees? Yes ☐ No ☐ Fee Amount Charged? $_____

To register contact: _____ Telephone #: _____

_____

This form must be filed with the Board not less than (60) days prior to the date of the program. Without adequate information, the Board cannot grant approval. Attach any additional information that would be helpful to the Board in determining approval. Any changes in a program must be reviewed and approved by Board. Failure to do so shall be grounds for revocation of approval.

I certify the information contained above and the attached documentation is complete and correct.

Person completing this application: (Please print)_____

Address: (If different from above)

_____

City/State/Zip: _____**Telephone:**_____

Signature:_____ **Date:**_____

For Board Use Only

	Activity/Program #: Provider #:		Check List:		
	On Agenda for: Meeting.		Complete Application		Roster Received
	Approved for: hours in Category		Instructor's Credentials/Vita		Other:
	Disapproved – Reason:		Agenda/Outline		
			Measurement Criteria		
	Signed:		Sample Certificate		
	(authorized board staff/reviewer) (Date)		Fee Enclosed		

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CONTINUING EDUCATION ATTENDANCE ROSTER

Course Name:	**Course Date:**
Provider Number:	**Course Number:**
Provider Name:	
Contact Person:	**Phone:**
Address:	

INFORMATION REGARDING LICENSEES

(ALL FIELDS MUST BE LEGIBLE AND COMPLETED TO ENSURE PROPER CREDIT FOR LICENSEE)

NAME/ADDRESS	SSN	LICENSE #	CREDIT HOURS	PASS/ FAIL

Signature of Instructor/Provider: _____

SAMPLE COURSE
ITENITARY/AGENDA

COURSE NAME
PROVIDER NAME
ADDRESS
DATE OF COURSE

8:30 A.M. - 9:00 A.M.	**REGISTRATION**
9:00 A.M. - 10:40 A.M.	**COURSE I**
10:40 A.M. - 11:00 A.M.	**BREAK**
11:00 A.M. - 11:50 A.M.	**COURSE II**
11:50 A.M. - 1:00 P.M.	**LUNCH**
1:00 P.M. - 2:40 P.M.	**COURSE III**
2:40 P.M. - 2:50 P.M.	**BREAK**
2:50 P.M. - 3:40 P.M.	**COURSE IV**

NOTE: PROVIDER REQUESTS <u>WILL NOT</u> BE APPROVED WITHOUT A COPY OF YOUR DAILY ITENITARY OR COURSE SCHEDULE.