



Department of Industrial Relations
Industrial Medical Council
P. O. Box 8888
San Francisco, CA 94128-8888

APPLICATION FOR ACCREDITATION OR RE ACCREDITATION AS EDUCATION PROVIDER

FOR OFFICE USE ONLY

APPROVED _____

DENIED _____

NO. _____

DATE _____

INITIALS _____

SECTION 1 PROVIDER

NAME OR PROVIDER: _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

DIRECTOR OF EDUCATION _____

PHONE () _____ **FAX** () _____ **E-MAIL ADDRESS** _____

TYPE OF ORGANIZATION _____

LENGTH OF TIME IN BUSINESS

NATURE OF BUSINESS/MISSION STATEMENT

PAST CONTINUING EDUCATION PROGRAMS

ACCREDITING AGENCIES WHO HAVE APPROVED PAST PROGRAMS

SECTION 2 - EDUCATION PROGRAM

PROGRAM TITLE

TYPE OF PROGRAM

**DISABILITY EVALUATION
REPORT WRITING COURSE**

**QME CONTINUING
EDUCATION PROGRAM**

DISTANCE LEARNING PROGRAM

DISTANCE LEARNING HOURS

TOTAL COURSE HOURS

PROGRAM OBJECTIVES

LOCATION(S) OF PROGRAM(S)

DATES

LOCATION(S) OF PROGRAM(S)	DATES

(1) INSTRUCTOR

HOUR(S)

TOPIC

CONTENT

(2) INSTRUCTOR

HOUR(S)

TOPIC

CONTENT

~~(3) INSTRUCTOR~~

~~HOUR(S)~~

~~TOPIC~~

~~CONTENT~~

~~(4) INSTRUCTOR~~

~~HOUR(S)~~

~~TOPIC~~

~~CONTENT~~

~~(5) INSTRUCTOR~~

~~HOUR(S)~~

~~TOPIC~~

~~CONTENT~~

~~(6) INSTRUCTOR~~

~~HOUR(S)~~

~~CONTENT~~

~~TOTAL NUMBER OF HOURS REQUESTED FOR APPROVAL~~

~~LIST OTHER ACCREDITING AGENCIES THAT HAVE APPROVED THIS PROGRAM~~

~~PRINTED NAME AND TITLE~~

~~SIGNATURE~~

~~DATE~~

~~**INSTRUCTIONS: Application for Accreditation as an Education Provider**~~

~~**SECTION 1. PROVIDER**~~

~~A "provider" is the individual or organization accredited by the Council to offer physician education programs.~~

~~**Name and address:** Provide the name and address of the individual or organization applying for accreditation as an education provider.~~

~~**Director of Education:** Provide the name, phone number, fax and e-mail of the Director of Education.~~

~~**Type of organization:** State whether the applicant is an individual; hospital; clinic or other patient care facility; educational institution; medical or health related organization whose membership includes Labor Code 3209.3 physicians; organization of non-medical participants in the California workers' compensation system; or a governmental agency.~~

~~**Length of time in business:** Provide this figure in years and months—for example, 4 years and 6 months.~~

~~**Nature of business/mission statement:** Briefly state the nature of the provider's business and its mission statement.~~

~~**Past continuing education programs:** List one or more education programs given by the applicant in the past two years. State the audience and subject matter of each program listed. List any accrediting agencies that have approved the programs listed above.~~

~~**SECTION 2. EDUCATION PROGRAM**~~

~~If applying for accreditation, complete this section for a proposed education program. If applying for re-accreditation, complete this section for a proposed program or for a program which was given during the completed accreditation period.~~

~~**Program Title:** State the title of the proposed education program.~~

~~**Type of Program:** Check the appropriate box.~~

~~**Distance learning:** Check the appropriate box.~~

~~**Objectives of Program:** List the education objectives of the proposed program.~~

~~**Location and dates of program:** Provide location (hotel, campus, etc.) and city where course will be held, with dates. Applicants for distance learning programs may omit this subsection, as appropriate.~~

~~**Instructors, Topics, Hours, and Course Content:** List each instructor (or author) for the proposed program, with relevant professional degree(s) (e.g., M.D., D.C.). Provide the topic or title of each presentation and the number of hours of credit requested for each presentation. Describe the content of the presentation. For distance learning programs, enter "Examinations" under "(1) Instructor" and estimate the time required to take the examinations.~~

~~**Other Accrediting agencies:** List all accrediting agencies that have approved the proposed program.~~

~~**Sign and date the application.**~~

~~**Additional pages may be appended to this application, as needed. Complete the entire application. Do not refer reader to attachments in lieu of completing the application. Incomplete applications will be returned to the applicant.**~~

~~**Submit one completed original application and two copies, each with the following attachments:**~~

- ~~1. one curriculum vitae for each instructor or author listed on the application, and~~
- ~~2. one copy of the proposed promotional brochure.~~

~~**The application must be submitted at least 60 days prior to advertisement of the program.**~~

~~**When the application has been approved and on or before the date this program is first given, submit the course syllabus (all course handouts) for the program. Providers of distance learning programs must also submit:**~~

- ~~1. one copy of the pre- and one copy of the post-test examinations, and~~
- ~~2. one copy of any video tape(s), audio tape(s), and/or computer program(s) (for video, audio and computer-based programs) used in the program; or~~
- ~~3. one copy of each issue of the printed educational material which contains text for which credit is requested (for programs based on journals or newsletters).~~