



NASW - Continuing Education
2 Year Unlimited CE PROVIDER APPLICATION COURSE PREAPPROVAL Form
Provider# _____

Please submit a separate application for each workshop. Allow **four to six weeks** for the workshop to be reviewed and to receive a response.

Two year unlimited – multiple different topic workshops

This category is for the delivery of an unlimited number of different topic and content workshops presented over a two year period. This category requires the application and all supporting documentation for **all** workshops being delivered under the two year unlimited category to be submitted 90 days before the workshop is delivered. This category allows a CE Provider to deliver an unlimited number of different content and topic workshop different presenters during a two year period. **All workshops under this category must be pre-approved.**

Date: _____ Provider # _____

Name of Organization: _____

Director: _____

Contact Person: _____

Address: _____

City/State/Zip _____

Phone: _____ FAX _____ Email _____

(Please complete the following information – ALL INFORMATION BELOW MUST BE SUBMITTED)

1. Title of Workshop/Class (INCLUDE A BROCHURE/FLYER)

2. Workshop is developed for (check as many as apply): Licensed Social Workers _____

Licensed Marriage & Family Therapists _____ Licensed Mental Health Counselors _____

3. Date of Course _____

4. Location of Course _____

5. Number of CEUs (1 CEU = 60 minutes of instruction) _____

6. Description of Workshop/Class (also attach course outline)

7. List workshop/course measurable objectives **(include how diversity and/or cultural competence will be addressed)**

8. Primary instructor name & title (attach vita and include copy of license, certification and/or registration)

9. Secondary instructor name & title, if applicable (attach vita)

10. Please submit a copy of your evaluation tool.

11. PLEASE LIST OTHER PROFESSIONAL ORGANIZATIONS THAT HAVE GIVEN YOU THEIR APPROVAL OF THIS OR OTHER COURSES OR WORKSHOP.

I declare that the enclosed documents are true. I understand that any false statements may result in the revocation of provider approval.

Signature of Director _____ Date _____

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FOR INFORMATION OR QUESTIONS CALL  
NASW Chapter Office  
Phone 206-706-7084

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| <p><b>FOR OFFICE USE ONLY:</b>    approved ____    denied ____    date _____    # _____</p> <p>Reason (if denied): _____</p> <p>Comments: _____</p> <p>_____</p> <p>Reviewer Signature</p> |
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