

Administrative Director, Division of Workers' Compensation  
ATTN.: Medical Unit  
P. O. Box 71010  
Oakland, CA 94612

**APPLICATION FOR ACCREDITATION OR  
RE-ACCREDITATION AS EDUCATION PROVIDER**

<b>FOR OFFICE USE ONLY</b>	NO. _____
APPROVED _____	DATE _____
DENIED _____	INITIALS _____

**SECTION 1 – PROVIDER**

**NAME OF PROVIDER** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**DIRECTOR OF EDUCATION** \_\_\_\_\_

**PHONE** \_\_\_\_\_ **FAX** \_\_\_\_\_ **E-MAIL ADDRESS** \_\_\_\_\_

**TYPE OF ORGANIZATION** \_\_\_\_\_

**LENGTH OF TIME IN BUSINESS** \_\_\_\_\_ **DWC PROVIDER NO.** \_\_\_\_\_

**NATURE OF BUSINESS/MISSION STATEMENT**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAST CONTINUING EDUCATION PROGRAMS**

\_\_\_\_\_

\_\_\_\_\_

**ACCREDITING AGENCIES WHO HAVE APPROVED PAST PROGRAMS**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION 2 – EDUCATION**

**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**

_____	_____
_____	_____
_____	_____

**(1) INSTRUCTOR** \_\_\_\_\_

**HOURS** \_\_\_\_\_

**TOPIC** \_\_\_\_\_

**CONTENT**

**(2) INSTRUCTOR** \_\_\_\_\_

**HOURS** \_\_\_\_\_

**TOPIC** \_\_\_\_\_

**CONTENT**

(3) INSTRUCTOR \_\_\_\_\_

HOURS \_\_\_\_\_

TOPIC \_\_\_\_\_

CONTENT

(4) INSTRUCTOR \_\_\_\_\_

HOURS \_\_\_\_\_

TOPIC \_\_\_\_\_

CONTENT

(5) INSTRUCTOR \_\_\_\_\_

HOURS \_\_\_\_\_

TOPIC \_\_\_\_\_

CONTENT

(6) INSTRUCTOR \_\_\_\_\_

HOURS \_\_\_\_\_

TOPIC \_\_\_\_\_

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 Administrative Director 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 new program or for a previously accredited 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 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. Syllabus and all handouts may be submitted on CD in lieu of hard copies. 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).