QUALITY CARE HEALTH FOUNDATION
2201 K Street, Sacramento, CA 95816
Phone: (916) 432-5185
Email: Cmerced@cahf.org

CAHF Chapter - QCHF CONTINUED EDUCATION (CE) REQUEST FORM

It is mandatory that all Chapter CE requests be submitted via email to Cheyenne Merced at cmerced@cahf.org

It is recommended that you save this document prior to completing to avoid losing valuable information

Fees are: **$ 249.00 for new request or renewal**
$ 189.00 for pre-approved class
Check Enclosed ☐
Deduct from Chapter Dues: ☐
Additional $50.00 Late Fee: ☐ **(updated 02/22/2023)**

Date of Request: ______________________ Date of Program: ______________________

New Program: ☐ (date of program must be at least 50 days away)

Pre-Approved Program: ☐ (date of program must be at least 10 days away)
C:\Users\CheyenneMerced\OneDrive - CAHF QCHF\Operations\QCHF\Education_Assistant_QCHF\Chapter_Documents

Title of Program: ______________________

Instructor Name: ______________________

Chapter Name: ______________________

Chapter Contact Person: ______________________

Phone Number: ______________________ E-Mail Address: ______________________

Facility Name: ______________________

Facility Address: ______________________

Location of Program: (Address) ______________________

Virtual / Web Based Documents Requested: ☐ **In Person Documents Requested**: ☐

Number of Hours Requested: _____ **(length of program rounded to the nearest hour)**

CREDITS DESIRED: (Licensure boards make final approval on all categories of credits approved).

☐ **NHAP** ☐ **NHAP(P)** ☐ **BRN**

If the program is pre-approved fill out this page only

All rates will automatically be charge/deducted based on the most up-to-date form posted to the CAHF website
https://www.cahf.org/Education-Events/Education/Programs-Services

COURSE INFORMATION

Program Date: ______________________________

Program Title: ______________________________

SPEAKER/INSTRUCTOR INFORMATION

(Must include resume or curriculum vitae)

PLEASE NOTE: All information must be complete for continuing education credit approval.

Instructor Name: ______________________________

Educational Credentials (degree and field) of speaker/instructor: ______________________________

License #: ______________________________

Years of teaching experience: ______

Years in long term care: ___________

DESCRIPTION OF COURSE

____

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____

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OBJECTIVES

(e.g., At the completion of this program participants will be able to describe, identify, understand, list, evaluate, demonstrate, etc.)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

AGENDA

(Must be completed in one hour increments)

First Hour: ______________________________

Second Hour: ______________________________

Third Hour: ______________________________

Fourth Hour: ______________________________

(If agenda requires additional class hours use a separate sheet of paper)

***CE associated with this training will only be recognized if all original evaluation forms, attendee list and completed tests (scoring at least 70%) are returned to QCHF*.**

If you would like the questions included in the evaluation that is provided please fill out the below and turn in with your CE Continued Education Request form

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Question 1:

A: ____ **B:** ____

C: ____ **D:** ____

Question 2:

A: ____ **B:** ____

C: ____ **D:** ____

Question 3:

A: ____ **B:** ____

C: ____ **D:** ____

Question 4:

A: ____ **B:** ____

C: ____ **D:** ____

Question 5:

A: ____ **B:** ____

C: ____ **D:** ____