

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:	\$ 259.00 for new request or renewal
	\$ 199.00 for pre-approved class
Check Enclosed	<input type="checkbox"/>
Deduct from Chapter Dues:	<input type="checkbox"/>
Additional \$50.00 Late Fee:	<input type="checkbox"/> (updated 10/24/2023)

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

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

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: _____