

# QUALITY CARE HEALTH FOUNDATION

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QUALITY CARE



## CAHF Chapter - QCHF CONTINUED EDUCATION (CE) REQUEST FORM

As of March 17, 2020, it is mandatory that all Chapter CE requests be submitted via email to Cheyenne Merced at [cmerced@cahf.org](mailto:cmerced@cahf.org)

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

<b>Fees are:</b>	<b>\$ 169.00 for new request or Renewal</b>
	<b>\$ 109.00 for pre-approved class</b>
<b>Check Enclosed</b>	<input type="checkbox"/>
<b>Deduct from Chapter Dues:</b>	<input type="checkbox"/>
<b>Additional \$50.00 Late Fee:</b>	<input type="checkbox"/> (updated 03/17/2020)

Date of Request: \_\_\_\_\_ Date of Program: \_\_\_\_\_

New Program:  (date of program must be at least 45 days away)

Pre-Approved Program:  (date of program must be at least 10 days away)

<https://www.cahf.org/Education-Events/QCHF/Programs-Services>

Title of Program: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

Chapter Name: \_\_\_\_\_

Chapter Contact Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Location of Program: (Address) \_\_\_\_\_

Web Based/On Demand 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 page one only**

All rates will automatically be charge/deducted based on the most up-to-date form posted to the CAHF website

**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)**