



**State of Delaware  
Office of Emergency Medical Services**

**Application for Continuing Education Credit**

Presenting Agency and Address:

Agency Contact:

Contact Phone:

Contact Email:

Course Name and Brief Description:

Total Hours Requested:  
BLS: \_\_\_\_\_  
ALS: \_\_\_\_\_

Course type:  
 Conference       Classroom/standard       Online/Hybrid

Post to DPH, OEMS training calendar website:  
 Yes       No

Course Location:

Name of Primary Instructor and Credentials:

Class Start Date:

Class End Date:

Class Times:

Signature of Agency Contact:

Date:

Name of Course Medical Director, Credentials and Date of Review:

- Please attach the following:**
- 1) Course Objectives
  - 2) Course Outline (include instructional hours per section)
  - 3) Post-Course Evaluation Tool (quiz, test, skill evaluation tool, class evaluation)
  - 4) Example, Course Completion Certificate

**OEMS Use Only Below This Line**

Received by OEMS (Initial/Date):

Reviewed By: (Initial/Date):

Medical Director Approval:

Date:

Comments:

Status:  
 Approved  
 Approved w/ Comments  
 Not Approved w/ Comments

Approval Number:  
**- CED -**

Approved Credit Hours:  
BLS: \_\_\_\_\_ ALS: \_\_\_\_\_