CONTINUING EDUCATION ADVISORY COUNCIL

MONTANA BOARD OF PHARMACY
(301 S PARK, 4TH FLOOR HELENA MT 59601- Delivery)
PO BOX 200513
HELENA MT 59620-0513
Phone (406) 841-2356 Fax (406) 841-2344

PROGRAM APPROVAL FORM

Please Type or Print Clearly

Applying for: ☐ Group Credit ☐ Individual Credit

Person Requesting Approval _____ Phone _____

Mailing Address _____

City State Zip

Name of Course Provider _____ Phone _____

Mailing Address _____

City State Zip

Title of Program _____

Presentation Location _____

City State Zip

Date of Presentation _____ Registration Fee _____

Estimated number of professionals participating _____ Pharmacists _____ Physicians _____ Nurses _____ Others _____
(Total)

Location of attendance records _____

SUBJECT	INSTRUCTOR	FORMAT	CLOCK HOURS

REQUIREMENTS:

1. Requester must maintain record of program, program approval number, and names and addresses of participants for 3 years.
2. Requester must award each attendee a certificate indicating program title, CEAC #, hours approved for group or individual credit, program date, attendee name, and presenter and/or sponsor name.
3. Requests should be submitted 30 days prior to the date of program. Failure to do so exposes participants to risk of disallowance of credit if program is found unacceptable.
4. Enclose a copy of the presenters CV or description of credentials and program handouts.

CEAC # _____ Approval Date _____ Reviewers Initials _____

(SAMPLE)

PHARMACY CONTINUING EDUCATION CERTIFICATE

GROUP CREDIT - # HOUR

MONTANA CEAC # XXXX

"TITLE OF PROGRAM"

PRESENTED BY

PRESENTATION DATE

PRESENTATION LOCATION

ATTENDEE NAME

_____

(SIGNATURE OF SPONSOR AND DATE OF SIGNATURE)