A. Provider Organization

Provider Organization Name: ________________________________________________________

Provider #(Tax ID):______________________________ Phone: ___________________________

OPA-MCE Program Administrator: _____________________________________________________

B. Course Information

Course Title: ______________________________________________________________________

Course ID #: _____________________(To be provided by OPA-MCE)

THE ABOVE COURSE QUALIFIES AS A COURSE IN ETHICS/CULTURAL COMPETENCY

☐ YES ☐ NO

Credit Hours (contact instruction hours): ______________________________________________

Course Date: 9-1-2022 (all distance learning courses are dated on the first day of the biennium)

C. Primary Instructor Information

Name: _____________________________________    Phone: ______________________________

Address: _________________________________________________________________________

City, State, Zip_____________________________________________________________________

D. Co-Sponsorship Information

(Complete the following information only if course is co-sponsored with another organization)

Name of Co-Sponsoring Organization: ________________________________________________

Contact Name: ____________________________ Phone: ________________________________

E. Attach all psychologists who have taken this course and send them in each quarter.

F. Authorization

I certify, on behalf of (Provider Organization), ______________________________ that the preceding statements are true. I understand that any false statements may result in the revocation of the provider approval. I understand that I am responsible for maintaining all standards outlined in the Provider’s Agreement and the Polices and Procedures Manual. I also understand that this course may be subject to an announced, random administrative audit.

Program Administrator       Date

07/07/22