AADSM
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www.aadsm.org

Date Received: For office use only

AMERICAN ACADEMY OF DENTAL SLEEP MEDICINE
Continuing Education Provider Application

Educational Provider

Name:		Address:	
City:	State:	Postal Code:	Phone:
Fax:	Website:		

Contact Person

Name: (Last)	(First)	(Middle)
Degree(s):	Title:	Phone:
Fax:	Email Address:	

Organization Type (Check one)

- ○ College/University/Dental School
- ○ Non-profit Organization
  Documentation to Provide: Non-profit organizations must provide a copy of the exemption determination letter issued by the IRS along with this application.

Recognized Continuing Education Provider Type (Check all that apply).

Documentation to Provide: copy of the most recent ADA CERP or AGD PACE decision report that verifies the recognition term

○ ADA Continuing Education Recognition Program (CERP)	○ AGD Program Approval for Continuing Education (PACE)

Type of Educational Offering (Select the format of the educational offering you are seeking recognition of.)

○ Lecture/Course/Seminar (live, in-person)	○ Self-Instructional (CE courses in printed or recorded format)
○ Online (live)	

Title (Complete the section below that applies. If additional space is needed, attach a seperate page to this application.)

Title of Educational Offering (if seeking recognition of entire course):	Title of Individual Session(s) (if seeking approval of select sessions within a course):
Title of Self-Instructional or Online Offering:	

Location & Date of Educational Offering (For live, in-person courses only)

Hotel/Facility:		
City:	State:	Date:

Will this Educational Offering be repeated? (For live, in-person courses only)

○ Yes	○ No

If yes, please provide the following information each time this course is scheduled to be repeated:

Course Dates	City	State	Hotel/Facility
1.			
2.			
3.			
4.			
5.			
6.			

Target Audience:

Educational Objectives

1.

2.

3.

To provide additional objectives, attach them to this application on a separate page.

Course Agenda (For live, in-person courses only)

Documentation to Provide: detailed course agenda that lists the titles, speakers and number of CE awarded for each session.

Declaration

As the official representative of the CE Provider as identified in this application, I hereby represent that **(i)** all information contained within this application and all documentation submitted with or in support of this application is true and correct; and **(ii)** I have read all current AADSM Guidelines and Protocols available at **aadsm.org/statementsguidelines.aspx** and agree that the content taught in our educational offering(s) aligns with these guidelines and protocols. I understand and agree that breach of any of the representation set forth above may result in revocation of the AADSM's recognition of our educational program(s) or other appropriate sanctions.

Name: (Please type or print clearly)

Signature:	Date:

Please submit the completed CE Provider Application to the AADSM National Office via e-mail **(qualifieddentist@aadsm.org)** or fax **(630-737-9790)**. A confirmation email will be sent to the contact person listed on the application within two business days from when it is received.