GEORGIA BOARD OF DENTISTRY

Injectable Pharmacologics Continuing Education Program
Application for Approval

Sponsoring Group: ____

Program Title: ____

Date of Program: ______ / ______ / __________

Program Site: ____

Intended Audience: ____

Goals/Behavioral Objectives: ____

Program: (Attach promotional material and/or program outline and short curriculum vitae for speakers. Also include a current schedule of where/when the courses are offered and if a member of the Board may audit the course.)

Please provide a letter of explanation regarding any sanctions or complaints associated with each provider/instructor, if applicable.

Method of Instruction: ____

Evaluation Method: (Attach copy of instrument used)______________________________

Person completing this form: ____

Address: ____

____

Phone Number: (   ) ________ - _________

Date: ______ / ______ / __________ Hours Requested: _________________

TO BE COMPLETED BY THE GEORGIA BOARD OF DENTISTRY

Date Received:___/____/______ Hrs. Approved:_______________________

Approved_____ Disapproved______ Date:____/_____/_________

Approved By:_______________________ Program #:_________________________

Comments:

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