

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: ____/____/_____ Hrs. Requested: _____

TO BE COMPLETED BY THE GEORGIA BOARD OF DENTISTRY

Date Received: ____/____/_____ Hrs. Approved: _____

Approved _____ Disapproved _____ Date: ____/____/_____

Approved By: _____ Program #: _____

Comments: _____