

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: _____

<u>TO BE COMPLETED BY THE GEORGIA BOARD OF DENTISTRY</u>	
Date Received: ____/____/____	Hrs. Approved: _____
Approved _____ Disapproved _____	Date: ____/____/____
Approved By: _____	Program #: _____
Comments: _____	
