THE DEPARTMENT OF HEALTH REGULATORY SERVICES
Health Practice Commission

COUNCIL FOR PROFESSIONS ALLIED WITH MEDICINE

Continuing Education Summary Form

Name:

Registration No:

Please list your Continuing Education (CE) classes/program completed and attach the certificates in the same order.

TYPES OF CONTINUING EDUCATION:			
LIVE	Presentations, seminars, conference/workshops attended.	**INTERNET**	Online CE Programs
WORK	Enhancing professional knowledge through work related activities **[must have letter signed by supervisor as proof]**	**FORMAL**	Education time towards a degree or certificate

TITLE OF PROGRAM	SPONSOR/PROVIDER	TYPE OF CE	DATE dd/Mmm/YYYY	HOURS
			CE TOTAL	

I certify that the above statement is a true and accurate record of the Continuing Education programs I completed. I am aware that any deliberate falsification included in this document will constitute a breach of good faith and result in the loss of one's license to practice. ☐ *Please see the continuation sheet (page 2)* ☐ *Final page*

Signature Date

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TITLE OF PROGRAM	SPONSOR/PROVIDER	TYPE OF CE	DATE dd/Mmm/YYYY	HOURS
			Page CE subtotal	
			CE GRAND TOTAL	

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Signature Date