Continuing Education Course Validation Request Form for Independent Studies

(Please type or print)

1) Course Title

2) Learning Objectives for Course

3) Course delivery model (check all that apply)
   ____ Computer based   ____ Video   ____ Audio   ____ Written Materials for correspondence study

4) Requested Date for validation (course will be validated for one year from this date)

5) Number of hours to be earned upon course completion (CEUs)   ______________

6) Course Type   _______   Practice Management   _______   Clinical

7) Course Designed for (check all that apply)
   __ General dentist   __ Specialist   __ Hygienist   __ Assistant   __Other

8) Facilitator (who created the course)

9) Credentials of the facilitator (education degrees, certification, etc.)

10) Phone number or e-mail address of facilitator

11) Reference for facilitator with email or phone contact information
12) List course on MDA website: (no additional cost apply)  _________ Yes  _________ No

Program Sponsor Contact Information

Name: ____________________________________________

Address: __________________________________________________________________________________

Phone: ___________________________ E-mail: _________________________________________________________

_I certify that the information listed on this application is accurate._

Authorizing Signature: ________________________________ Date: _____________________________

Continuing Education Course Validation Fees for Independent Studies

**Practice Management Programs**

<table>
<thead>
<tr>
<th>Hours</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>.5 – 4</td>
<td>$350.00</td>
</tr>
<tr>
<td>5 – 8</td>
<td>$550.00</td>
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</tbody>
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**Clinical Programs**

<table>
<thead>
<tr>
<th>Hours</th>
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</thead>
<tbody>
<tr>
<td>.5 – 4</td>
<td>$500.00</td>
</tr>
<tr>
<td>5 – 8</td>
<td>$700.00</td>
</tr>
</tbody>
</table>

Please remit completed application and payment by check to the MDA Office.

MDA Office Use Only

MDA Course Registration Number: 201920MDA_____