## Kentucky Department of Insurance Continuing Education/Pre-Licensing Program

## **Provider Approval Application**

☐ Continuing Educa	ation		• •				
☐ Pre-Licensing							
PLEASE PRINT OR TYPE	E. PHOTOCOPY AS NEEDED.						
Provider Name		FEIN		Prometric Use Only			
Names and Titles of Owners or Officers (list below)  Name			Title				
Address							
City			State	Zip C	ode		
Contact Person	ntact Person		Title				
Voice Phone #:	Ext.		Fax #:			E-mail Address	
URL: (Web site address)	S .			have you b	ave you been in business?		
Type of ☐ Insurance Company ☐ Professional Organization Organization: ☐ Independent Provider ☐ College/University (check one) ☐ Government Entity  New Providers for the Commonwealth of Kentucky must include approval or exemption docum					ent from the Kentucky		
Board for Proprietary Education. For additional information on this requirement, please visit that Web site at: <a href="http://bpe.ky.gov">http://bpe.ky.gov</a> or phone directly (502) 564-3296.							
	nder any other name?	☐ Yes	□ No	If yes,			
Name			Address				
I certify that I have read the requirements for Kentucky Pre-License Training or Continuing Education Providers and agree to abide by them and will abide by Kentucky insurance laws and regulations, the Americans with Disabilities Act, and all applicable state and federal equal employment opportunity and safety requirements. Additionally, I will require any instructors I utilize to teach courses to certify that they satisfy the requirements to be an instructor and to abide by those requirements applicable to instructors. I am aware that any failure to abide by the requirements may result in the termination of this Provider's authorization to offer courses and that all course approvals will be simultaneously withdrawn.							
Applicant's Signature					Date		
Print or Type Name					Title		