

State of Florida
Department of Business and Professional Regulation
Regulatory Council of Community Association Managers
Application for Continuing Education Provider Approval or Renewal
Form # DBPR CAM 8

APPLICATION CHECKLIST – IMPORTANT – Submit all items on the checklist below with your application to ensure faster processing.

APPLICATION	APPLICATION REQUIREMENTS
Continuing Education Provider Approval/Renewal	<input type="checkbox"/> Complete all sections of this application. <input type="checkbox"/> Pay \$250 application fee (make check payable to the Department of Business and Professional Regulation).

Please mail your completed application, documentation to:

Department of Business and Professional Regulation
 2601 Blair Stone Road
 Tallahassee, FL 32399-0783

Instructions

*If you have any questions or need assistance in completing this application, please contact the Department of Business and Professional Regulation, Customer Contact Center, at **850.487.1395**.*

1) **General Requirements**

- a) To maintain Provider status in good standing, providers must adhere to all provider requirements outlined in [Rule 61E14-4.002, Florida Administrative Code](#); and [Section 455.2178, Florida Statutes](#).
- b) Provider approval is valid until May 31st of odd numbered years and must be renewed.

2) **Application Instructions (by section)**

a) **Section I- Application Types**

- i. Continuing Education Provider – Individual : Select this application type if you are an Individual applying to be a Continuing Education Provider
- ii. Continuing Education Provider – Organization: Select this application type if you are an Organization applying to be a Continuing Education Provider

b) **Section II- Applicant Information**

- i. Fill out each section completely.
- ii. In the “Applicant Information” section, applicants must use their name as it appears on his or her social security card. Do not use any nicknames or initials.
- iii. If applying as an Organization or Company, provide the name of the company or organization that will provide educational services.
- iv. A Social Security number is required in order to apply for any individual license within the Department of Business and Professional Regulation.
- v. If you are applying as an Organization or Company you must provide the Federal Employer Identification Number (FEID) for the business.
- vi. If the applicant provides other educational services for another board within the Department of Business and Professional Regulation, please provide those provider approval numbers.
- vii. Provide your mailing address. This will be used for sending correspondence regarding your application.
- viii. Applicants must provide their business location address.
- ix. Contact information is often used to quickly resolve questions with applications by telephone call or email. If contact information is not provided, questions regarding applications will be mailed to the applicant’s mailing address and may take longer to resolve.
- x. Additional contact information is optional and will be used when the applicant cannot be reached using their primary contact information.

c) **Section III- Affirmation by Written Declaration**

- i. Each applicant must sign the affirmation by written declaration.

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For additional information see the Instructions at the beginning of this application.

Section I – Application Type

CHECK ONE OF THE APPLICATION TYPES	
<input type="checkbox"/>	Continuing Education Provider- Individual [3804/1030]
<input type="checkbox"/>	Continuing Education Provider- Organization [3804/1030]

Section II – Applicant Information

APPLICANT INFORMATION <i>(Provider/Owner)</i>			
Last/Surname	First	Middle	Suffix
Company/Organization Name			
Social Security Number (if applying as an Individual)*			
Federal Employer ID Number (if applying as an Organization)			
GENERAL IDENTIFICATION			
Is Provider approved by any other board within the Department of Business and Professional Regulation to provide continuing education?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what is the provider approval number?			
MAILING ADDRESS			
Company Name			
Street Address or P.O. Box			
City	State	Zip Code (+4 optional)	
County (if Florida address)	Country		
BUSINESS LOCATION ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)			
Street Address			
City	State	Zip Code (+4 optional)	
County (if Florida address)	Country		

Section II – Applicant Information- continued

CONTACT INFORMATION				
Last Name (Authorized Representative) First		Middle	Title	Suffix
Primary Phone Number		Primary E-Mail Address		
ADDITIONAL CONTACT INFORMATION (OPTIONAL)				
Alternate Phone Number			Fax Number	
Alternate E-Mail Address				

* The disclosure of your Social Security number is mandatory on all professional and occupational license applications, is solicited by the authority granted by 42 U.S.C. §§ 653 and 654, and will be used by the Department of Business and Professional Regulation pursuant to §§ 409.2577, 409.2598, 455.203(9), and 559.79(3), Florida Statutes, for the efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. It is also required by § 559.79(1), Florida Statutes, for determining eligibility for licensure and mandated by the authority granted by 42 U.S.C. § 405(c)(2)(C)(i), to be used by the Department of Business and Professional Regulation to identify licensees for tax administration purposes.

Section III – Affirmation By Written Declaration

AFFIRMATION BY WRITTEN DECLARATION	
I certify that I am empowered to execute this application as required by Section 559.79, Florida Statutes. I understand that my signature on this written declaration has the same legal effect as an oath or affirmation. Under penalties of perjury, I declare that I have read the foregoing application and the facts stated in it are true. I understand that falsification of any material information on this application may result in criminal penalty or administrative action, including a fine, suspension or revocation of the license.	
Signature:	Date:
Print Name:	