



Kentucky Department for Public Health

Application for Approval of Community Health Worker Continuing Education Credits

Thank you for your interest in providing continuing education credits for Certified Community Health Workers (CCHWs) in Kentucky. This form must be completed for each training in which you wish to provide continuing education credits. **All applications must be submitted at least four (4) weeks prior to the training.**

In order to receive one contact hour, the training must provide “at least 50 minutes of continuous participation.” For additional details please refer to the Kentucky Community Health Worker Certification Manual.

Once submitted, applications will be reviewed by Kentucky Department for Public Health Community Health Worker program staff. All applicants will be notified in writing regarding approval at least five (5) days prior to the date of the training listed on the application.

Approved trainings must provide (and retain copies of) a certificate of completion for each CCHW that successfully completes the training. Certificates should be kept for a minimum of three (3) years. The certificate must include:

- Name of Training Organization
- Title of Training
- Date of Training
- Name of the CCHW

Additionally, all certificates and agendas **must** include the following statement:

“This training has been approved by the Kentucky Department for Public Health Community Health Worker Program to provide X continuing education hours for Certified Community Health Workers.”

Applications may be sent via mail or email to:

Mail

Kentucky Department for Public Health
Community Health Worker Program
275 E. Main Street, HS2W-E
Frankfort, Kentucky 40621

Email

CHW.Certification@ky.gov
Subject Line: CHW Continuing Education
Application

For State Use Only:			
Application submitted four weeks prior to training:	<input type="checkbox"/>	Yes	<input type="checkbox"/> No Date_____
Course approved?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No # CEs_____
Name of KDPH Representative _____	Date_____		
Signature of KDPH Representative_____			

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Program Information

Organization Name:		
Training Coordinator Name:		
Mailing Address:		
City:	State:	Zip Code:
Phone Number:	Email:	

Training Information

Training Event Title:	Dates(s):
Facility Name:	
Address:	
City:	State: Zip:
Expected Audience Size:	Number of CE Hours Requested:
Cost of Training:	
Training Occurrence:	
If this is a reoccurring training, please indicate how often it will take place and on which dates. .	
<input type="checkbox"/> Annually <input type="checkbox"/> Bi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	Date(s)
Please describe the registration process for this training. If advanced registration is required, please <u>provide a copy of the registration form or link to the online registration.</u>	
Target Audience:	
Training Description:	

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Training Objectives:		
CHW Competencies to Achieve:		
All Training instructor names, degrees/certifications, and current positions:		
Evaluation Materials Included? (Required)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Attestation

I attest that all of the information provided in this document is true and complete. I understand that providing false or misleading information may result in the denial or revocation of continuing education hours.

I attest that the technical and education competencies of the training instructor(s) are relative to the program objectives.

I understand that this application and all supporting documentation become the property of the Kentucky Department for Public Health and are not returnable.

I attest that I understand this activity must be free of commercial bias for or against any product and is evidence-based.

Training Coordinator Signature

Date