Alabama State Board of Respiratory Therapy
P. O. Box 241386, Montgomery, AL 36124-1386
Phone: 334-396-2332 Fax: 334-396-2384
Web Site: www.asbrt.alabama.gov

Notification of Continuing Education Offering

Provider number: _____

Date: _____

Organization Name: _____

Course/Class Date: _____ **Time: _____**

Location: _____

Address: _____

_____
City State Zip Code

Phone: _____

Will partial credit be available: ____ yes ____ no
(for multiple hour offerings only)

Topic	**Instructor, Credentials**	**Start Time / End Time**	**Contact hours**
1. .			
2.			
3.			
4.			
5.			

Attach additional sheet if more room is needed.

A complete agenda, class objectives, instructor credentials, and roster of attendees shall be maintained by organization for 3 years. A list of attendees licensed by the ASBRT and number of hours awarded shall be sent to the ASBRT within 30 days of the presentation date.

Education Coordinator signature: _____
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Official ASBRT use only:
Date received: _____
Date roster received: _____