ARKANSAS INSURANCE DEPARTMENT
APPENDIX C
CONTINUING EDUCATION PROVIDER APPLICATION

Name of Provider: _____

Address: _____
Street or P.O. Box City State Zip

Phone Number: _____ Fax # _____

Name of Contact Person #1 _____

Contact Person Phone # _____ Fax # _____

Contact Person E-mail: _____

Name of Contact Person #2 Contact Person Phone # _____

Contact Person E-mail: _____ Fax # _____

What other States are you approved as a Provider of Continuing Education: _____

_____

List Representatives Authorized to Sign Certificates for Provider:

_____

Name Title Signature

_____ Name _____ _____ Title _____ _____ Signature _____

_____ Name _____ _____ Title _____ _____ Signature _____

Type of Courses Provider Will Offer: (check all that apply)

_____ _____ _____

_____ Producer (agent/broker) _____ Title _____ Adjuster

Signed _____

Printed Name _____

Title _____

Dated _____

*******THIS FORM IS TO BE SUBMITTED WITH A REGISTRATION FEE OF $100*******

For Department Use:
Fee Received: _____ Check or Route Slip: _____

Approved by _____ Date: _____

Disapproved by _____ Date: _____

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