



IOWA INSURANCE DIVISION

Continuing Education Program

Provider Approval Application

Please Print or Type. Photocopy as Needed.

Provider Name:			
Names and Titles of Owners or Officers <i>(list below)</i> :			
NAME		TITLE	
Address:			
City:		State	Zip Code
Contact Person:			
Voice Phone:	Ext.:	Fax:	Email Address:
How long have you been in business as a CE Provider?		Attach copy of refund policy	
Type of Organization: <input type="checkbox"/> Professional Organization (check one) <input type="checkbox"/> Insurance Agency/Brokerage/Wholesaler		<input type="checkbox"/> Training Company <input type="checkbox"/> College/University	<input type="checkbox"/> Insurance Company <input type="checkbox"/> Other _____
Have you operated under any other name? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, provide the name and address of each business under whose name you have operated (see instructions for details).</i>			
NAME		ADDRESS	
Has the provider or any officer, partner, or owner ever had any disciplinary action, including but not limited to, refusal, suspension, or revocation, taken by any regulatory agency in any state or any province of Canada against them or any business with which they have been directly connected? <input type="checkbox"/> Yes (If yes, provide a full explanation on a separate sheet of paper.) <input type="checkbox"/> No			
Has any officer, partner, or owner of the provider been convicted of, or pled nolo contendere (no contest) to, any misdemeanor or felony; or does any officer, partner, or owner currently have pending misdemeanor or felony charges against them? (Do not include minor traffic violations.) <input type="checkbox"/> Yes (If yes, provide a full explanation on a separate sheet of paper.) <input type="checkbox"/> No			
I certify that I have read the program requirements for Iowa Continuing Education providers, agree to abide by those requirements, and will abide by Iowa 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 program requirements applicable to instructors. I am aware that any failure to abide by the guidelines may result in the termination of this Provider's authorization to offer courses and that all course approvals will be simultaneously withdrawn. Please allow 30 days from date of receipt by Pearson VUE for processing.			
_____ Applicant's Signature		_____ Title	
_____ Print or Type Name		_____ Date	

Mail with \$75 fee to: **Pearson VUE, Attn: Iowa Ins CE Approval, PO Box 8588, Philadelphia, PA 19101-8588**
 For time sensitive material mail with \$75 fee to: **Pearson VUE, Attn: IA CE Approval, 3 Bala Plaza W Ste. 300, Bala Cynwyd, PA 19004-3481**