

**APPLICATION FOR  
APPROVED PROVIDER STATUS**

**NORTH DAKOTA BOARD OF  
SOCIAL WORK EXAMINERS  
PO BOX 914  
BISMARCK, ND 58502-0914  
PHONE 701-222-0255  
FAX 701-224-9824  
E-MAIL: [ndbswe@aptnd.com](mailto:ndbswe@aptnd.com)  
[www.ndbswe.com](http://www.ndbswe.com)**

Please Type or Print Clearly.

**Identification:**

**Provider Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Describe Qualifications:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I/We hereby apply for approved provider status for continuing education. I/We hereby attest that I/We have received a copy of the guidelines and criteria regarding continuing education and agree to present programs that meet the North Dakota Board of Social Work Examiner's criteria governing continuing education for social workers.

\_\_\_\_\_  
Administrator

\_\_\_\_\_  
Continuing Education Coordinator

Date: \_\_\_\_\_

**\*\*Please return completed form with fee to above address.**

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**DO NOT WRITE BELOW THIS LINE**

\_\_\_\_\_ [ ] has/ [ ] has not been granted an "Approved

Provider" status for continuing education by the North Dakota Board of Social Work Examiners, effective

\_\_\_\_\_ to \_\_\_\_\_.

Provider number: \_\_\_\_\_

\_\_\_\_\_  
Continuing Education Monitor